# HEALTH AND ACCIDENT INSURANCE POLICIES

UNDER THE

## STANDARD PROVISIONS LAW

## REPORT OF AN INVESTIGATION

BY

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## FOREWORD

A number of persons interested in health and accident insurance have urged that the accompanying report be printed and have offered to bear personally the expense of publication and circulation. The acceptance of these offers has not seemed fair to me and the arrangement for publication has been made so the expense will be borne by those who should receive the benefit.

The value of the report lies in the fact that it is, I believe, the first attempt to cover the subject in its entirety. I am indebted to all the health and accident insurance men and women, company officials, employes, and agents who have discussed the subject with me, to those who have presented complaints to the department on settlements, to officials and employes in insurance departments and to persons interested in other lines of insurance, for the clarification and systematization of the ideas of health and accident insurance presented. I desire especially to express my appreciation to Mr. L. A. Anderson, Chief Actuary of the Central Life Assurance Society of Des Moines, Iowa, for encouragement given to me over a period of years to persist in the study of this branch of insurance, so crude in its organization and development but of such unlimited possibilities, and for insisting that I hold fast during such study to the fundamentals of insurance.

My earnest hope is that the publication of this report will assist in the development, proper organization, and growth of this branch of insurance.

THOMAS P. NELSON.

October 6, 1919.

Hon. Platt Whitman,
Commissioner of Insurance,
Madison, Wisconsin.

Dear Sir:

I submit, herewith, a report of the investigation of Health and Accident Policy Forms.

The report is divided into two parts. Part I gives the argument for the form prepared as a Standard Health and Accident Policy Form, providing all the insurance authorized by the Standard Provisions Law. Part II is a discussion of the criticisms and objections made to the Standard Form by the insurers.

Respectfully submitted,

Thomas P. Nelson,
Health and Accident Policy Examiner.

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## PART I

PART II

# Health and Accident Insurance Policies under the Standard Provisions Law

On May 21, 1919, and August 29, 1919, respectively, the attached letters and forms were sent out from the Department.

Only the Revised Policy is printed. The Optional Indemnities suggested on May 21 follow the policy.

May 16, 1919.

To the Person Addressed:

Mr. Nelson, health and accident policy examiner in this department, has made an exhaustive study of the problem of health and accident insurance. He has asked permission to submit a form of health and accident policy for criticism and suggestion. Permission has been granted, and he is submitting his policy form.

Yours very truly,

PLATT WHITMAN,
Commissioner.

May 21, 1919.

I am enclosing herewith a copy of a health and accident insurance policy form which is designed to provide all of the insurance authorized by the Standard Provisions Law. Any of the kinds of insurance, namely, loss of life by accident, loss of time by accident, loss of time by disease, loss other than that of time by accident, and loss other than that of time by disease might be omitted from a policy, or a policy might provide insurance for any one or more of them. The amount of insurance provided for any of these kinds of insurance and the period during which payments would be made might vary for each kind of insurance.

Provision is made, in accordance with the law, as you will observe, for excepting from a policy any accident or disease, or classes of either of them. Where an applicant has already suffered a specific bodily loss, the amount of insurance provided for loss of time and the amount of the periodic benefits might be reduced by a rider to be attached to a policy. The insurer might be relieved from liability for loss other than that of time by an exception in the body of the policy. Where an applicant is afflicted with a chronic or recurrent disease as shown by the application, the insurer might be relieved from liability for loss from the disease by exceptions in the body of the policy.

The restrictions and limitations in policy forms now issued, namely, immediate disability from accident, the attendance of a physician or surgeon, confinement to the house, etc., have been omitted, because the law does not authorize these kinds of insurance, and, therefore, they are not properly parts of a contract, but pertain to the proof of loss. For the same reason the common provisions for the payment of reduced benefits in cases of partial disability have been omitted and also because they are in conflict with the regulations of the Standard Provisions Law, prohibiting any provision in a policy "limiting the amount of indemnity to a sum less than the amount stated in the policy."

The "Optional Indemnities" enclosed herewith are merely suggestive. The insurer could modify, limit, restrict or enlarge them in any way desired. An optional indemnity might be formulated to provide for claims where loss of time was not total. These optional indemnities concern the adjustment of claims and are to relieve claimants from the necessity of making periodic proof of loss and the insurer from clerical work in adjusting claims. They should not be incorporated into the policy proper, but might be endorsed or printed thereon or attached thereto.

Under the policy form submitted, claims would be proved on forms somewhat different from those now used. Claimants might be required to show when disability began, when and where a physician attended, whether or not they were confined to the house, what duties of their occupations they were unable to perform, what income had been lost, what expenses had been incurred, etc. The purpose of the forms would be to obtain evidence of actual loss from a cause covered by a contract.

This form is submitted to you for criticism and to obtain suggestions, in the hope that through simple, honest policy forms the business may be put upon a better basis, and the department thereby be freed from the greatest source of complaints.

Yours very truly,

THOMAS P. NELSON,

Health and Accident Policy Examiner.

August 29, 1919.

Dear Sir:

Enclosed herewith is a revision of the Health and Accident Policy Form sent to you with my letter of May 21, 1919.

The phraseology has been changed by the greater use of phraseology from the Standard Provisions Law. The only substantial change in the policy is the elimination from the portion of the policy providing indemnity for "loss other than that of time from accident or sickness" of the provision for the periodical ascertainment and payment of indemnity. This elimination has been made because the lapse of time does not measure the loss to the insured due to expense for care and treatment of the person of one suffering from disability.

It was very apparent that many of the writers of criticisms of the policy form submitted had not made a care-

ful study of the Standard Provisions Law under which health and accident policies must be formulated. I desire, therefore, at this time, to reiterate the opening statement of my letter of May 21, regarding the policy form submitted, namely, that "the policy form is designed to provide all the insurance authorized by the Standard Provisions Law". If you have any criticisms or suggestions, which will further this design, I shall be very glad to receive them.

Yours very truly,

THOMAS P. NELSON,
Health and Accident Policy Examiner.

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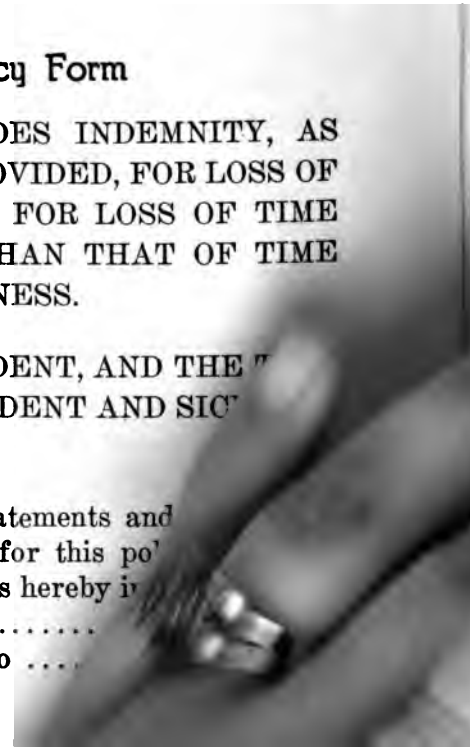
## Revised Policy Form

1. THIS POLICY PROVIDES INDEMNITY, AS HEREIN LIMITED AND PROVIDED, FOR LOSS OF LIFE BY ACCIDENT, AND FOR LOSS OF TIME AND FOR LOSS OTHER THAN THAT OF TIME FROM ACCIDENT OR SICKNESS.

2. THE LIFE FROM ACCIDENT, AND THE
AND EXPENSE FROM ACCIDENT AND SIC
INSURANCE COMPANY.

3. In consideration of the statements and
tions made in the application for this po
premium of ..... dollars hereby i
inafter limited and provided, .....
from ..... to ....



3. Substitute where the premium is to be paid in instalments.

In consideration of the statements and representations in the application for this policy and of a premium of .....dollars, which premium is to be paid in ..... instalments on or before ..... of each ....., hereby insures, as hereinafter limited and provided, ..... ..... from ..... to ....., which insurance is subject to lapse by the failure of the insured to pay any instalment of the premium as hereinbefore provided and to reinstatement after lapse as provided in Standard Provision Number 3.

4. LOSS OF LIFE BY ACCIDENT

This policy provides indemnity for loss of life of the insured by accident in the sum of ..... dollars.

5. LOSS OF TIME BY ACCIDENT

This policy provides indemnity for loss of time from the bodily injury of the insured by accident, except ..... ..... in the sum of ..... dollars, which indemnity is payable as provided in Standard Provision No. 10, at the rate of ..... dollars per month for the period of ..... months, subject to due proof of loss or damage by the insured.

6. LOSS OF TIME FROM SICKNESS

This policy provides indemnity for loss of time of the insured from sickness except ..... in the sum of ..... dollars, which indemnity is payable as provided in Standard Provisions No. 10, at the rate of ..... dollars per month for the period of ..... months, subject to due proof of loss or damage by the insured.

## 7. LOSS OTHER THAN THAT OF TIME FROM ACCIDENT OR SICKNESS

This policy provides indemnity for loss other than that of time for expenses (medical, hospital and nursing expenses, and expenses for medical appliances) necessarily incurred by the insured in the care and treatment of his person and resulting from sickness, except ..... ..... or the bodily injury of the insured by accident except ..... in the sum of ..... dollars, subject to due proof of loss by the insured.

## 8. STANDARD PROVISIONS

9. IN WITNESS WHEREOF, The Life from Accident, and the Time and Expense from Accident and Sickness Insurance Company has caused this policy to be issued by its subscribing officers at Paradise, Wisconsin, this ..... day of ....., 19....

.....
President.

.....
Secretary.

## OPTIONAL INDEMNITIES

(May be used if the policy does not provide indemnity for loss of life from accident.)

ACCIDENTAL DEATH. If such injuries shall be the sole cause of the death of the assured, upon due proof, the designated beneficiary shall have the option of taking the present value of the unaccrued indemnity for loss of time commuted at the rate of six per cent annual interest.

SPECIFIC INJURIES. If such injuries shall be the sole cause of a specific bodily loss named in the schedule below, for thirty days thereafter the assured shall have the option of taking the present value of the unaccrued indem-

nity commuted at six per cent annual interest and based on the relation of such specific loss to the maximum indemnity as follows:

Loss of both hands, the Maximum Indemnity
Loss of both feet, the Maximum Indemnity
Loss of one hand and one foot, the Maximum Indemnity
Loss of both eyes, the Maximum Indemnity
Loss of one hand or foot, One-third the Maximum Indemnity
Loss of one eye, One-third the Maximum Indemnity

Loss of hand or foot shall mean complete severance at or above the wrist or ankle joint. Loss of one or both eyes shall mean total and irrecoverable loss of sight thereof.

Surgical Operations—Reimbursement. If bodily injury or disease covered by this policy necessitates an operation described in the schedule set forth below, and such operation is performed upon the insured by a surgeon within ninety days from the date of accident or commencement of disability by disease, the company, in lieu of the indemnities otherwise payable for loss other than that of time (including medical and hospital expenses, expense of nurse, etc.), will reimburse the insured the amount expended by him for such operation not exceeding the limit therefor according to the said schedule. If more than one such operation shall be performed on account of injuries sustained in any one accident, or on account of one illness, the limit of reimbursement shall be the largest sum specified in the schedule for any one of the operations so performed.

## SCHEDULE

Abscess or Cellulitis, Incision..... $.....
Abdomen, Cutting into Abdominal Cavity for diagnosis or treatment of organs therein ..... .....

AMPUTATION OF

Entire Hand, Forearm, or Foot ..... $.....

.....

.....

.....

APPENDICITIS, ..... .....

..... .....

..... .....

..... .....

REGISTRATION AND IDENTIFICATION. The company has registered the name of the assured upon its records at its home office. If by reason of accidental injury while this policy is in force the assured shall be unable to communicate with friends or relatives, the company will defray all necessary expenses of placing the assured in communication with and in care of friends or relatives, not exceeding the sum of ..... dollars. The benefits given by this paragraph are in lieu of, and are to be deducted from the benefits to which the insured may be entitled for loss other than that of time.

# PART I

## Attitude of Insurers Before Enactment of Standard Provisions Law

An examination of Health and Accident Insurance Policies issued before the enactment of the Standard Provisions Law and deductions from the report of the examiners for the National Convention of Insurance Commissioners in 1911 discloses that the insurers whose operations fixed the plane of the business exercised powers, claimed rights, and indulged in practices in disregard of their duties and obligations. These insurers insisted they had a right to make any kind of contract they pleased with individuals. The right to contract was free, unlimited, unregulated, and unrestricted. Summarized, the claims of these insurers might be stated as follows:

*An insurer had a right to issue a contract providing a specific benefit* (regardless of the loss or damage suffered), *for a particularly described bodily loss or disability* (i. e., death to occur within a certain time of the accident; death not to be by reason of infection; loss of hand or foot to be above a certain joint; loss of sight to be irrecoverable; disability to be immediate on the accident; disability to be of such a character as necessarily to confine claimant to his bed, or house; disability to be such as to make claimant unable to perform a certain part of his work, all, three-quarters, one-half, one-quarter; disability to be such as to require the weekly attendance of a legally qualified physician or surgeon, etc.); *from a particularly described accident or disease or a class of such accidents or diseases* (i. e., wrecking of a railroad passenger car or vessel; struck by lightning; burning building; automobile accident; travel accident; accident in insured's occupation; accident not in occupation; accident in certain place; accident at certain time;

tuberculosis; boils; carbuncles; felons; lumbago; diseases of generative organs; insanity; heart disease; cancer; disease of respiratory organs, etc.). The premium in such contracts need not be common to the insured; there might be a different rate for every individual. Indemnity for loss was not basic to such contracts. The bodily losses or disabilities and the specific benefits therefor included in such contracts might vary with every contract. The accidents and diseases included in these contracts might vary with each contract.

It might be stated as a fact that these policies were formulated at first for individuals. Later, they were issued to classes made either by occupation or because of exposure to a like hazard as to certain accidents or diseases, or a like hazard of specific bodily losses, either in a sub-class of an occupation or outside of occupation. Still later, they were issued to any and every person regardless of their applicability to the individuals insured under them. (For instance, a travel accident policy fairly reasonably insuring a traveling salesman in his occupation, would be issued to a farmer who did not travel on a railroad once a year; or a policy calculated to insure against the loss of a hand by a punching machine would be issued to an office clerk where there was practically no liability to meet with the loss specified).

The following is quoted from the president of a casualty company on the character of the policies issued by the insurers.

> "The primary object of this sort of protection was and should be, to provide an income to the wage-earner when his wages are cut off by unfortuitous circumstances. The principal object of the first underwriters seemed to be the production of somethings that could be sold. Therefore, in order to furnish a marketable commodity they sought to issue a policy at a popular price and the almost universal price was $1.00 per month. The attempt was made to confine the benefits promised to what a dollar would

pay for, but lack of experience made it practically impossible to determine with any degree of accuracy just what could be promised for such a premium, having in mind the great diversity in the occupations and habits of the insured; and as the competition increased, greater and more fanciful promises were made until the policy became more of a literary and insurance monstrosity than the product of scientific underwriting. As one company would add a liberal provision to its policy, the other companies would try to outdo it, until finally the policies were so prepared that it would require a mathematician to determine what, if anything, a policyholder was entitled to in case of a claim. The policy would provide for a certain amount of indemnity in case of accident, or sickness, then in some hidden clause there would be a provision that only a fraction of the amount promised would be payable under certain conditions, and a different fraction under slightly different conditions, and so on, until a study of the policy forms in general led one into a maze from which he was only able to extricate himself by giving the matter up in disgust. This condition existed until within a very few years, when by the aid of accumulated experience, the disadvantage and undesirability of these added curiosities became apparent and it was soon demonstrated that the companies must prevent the loss which a liberal construction of such policies would entail. This was attempted by cutting down the claims and refusing payment on the slightest technicality."

It is fitting at this point to observe that the settlements of claims were very unsatisfactory under the conception of health and accident insurance which makes liability dependent on the occurrence of a particular disease, or an accident happening from a particular instrument, or at a definite time or place, or resulting in a specific bodily loss or disability, and the amount of liability a guilded guess of the insurer, to call attention to the address of Honorable John T. Winship, of Michigan, before the National Convention of Insurance Commissioners in 1915,

in which he points out the fraud and deceit which are practiced when a special or limited accident or health policy is foisted upon a person not liable to the hazard covered, and the injustice and inequity which are perpetrated when the phrases, "confinement to the house," "attendance of a physician," "total disability," and similar phrases are applied literally in the settlement of claims.

### Attitude of Courts

When policies of the character described came before the courts for construction they were held to provide insurance against loss from accident or sickness. The limitations or restrictions on the character of the disability, designed to determine liability, were held inapplicable, or the courts held that the particular disability or loss on which the claim was based was included within the meaning of the contracts. The insurers constantly and persistently endeavored to limit recovery to the amounts provided for specifically described bodily losses or disabilities, which in turn were restricted and limited by other clauses in the policies to those resulting from certain accidents or diseases, and rejected claims for indemnity for losses not resulting from bodily losses, injuries, or disabilities particularly described in the policies and from certain accidents and diseases. The following quotation from Richards sums up the general attitude of the courts:

> "The accident policy illustrates conspicuously, on one hand, the disposition of the insurers to narrow liability by the addition of restrictive clauses, and, on the other hand, the determination of the courts to hold the company to the principal obligation of the contract by evading exceptions which are unreasonably inconsistent with the main purpose of the contract."

The courts looked to the cause of loss and generally disregarded exceptions of results as misleading and deceiving the insured. Sheanon v. Pac. Mut. Life. Ins.

Co., 77 Wis. 618; Lord v. Am. Mut. Acc. Ass'n, 89 Wis. 19. It is true that the courts were not always consistent in their holdings but this was the final and general consensus of the opinions. See notes in L. R. A. and A. & E. Ann. Cases on "confinement to the house," "blood poisoning," etc. See also Cary v. Preferred Acc. Ins. Co., 127 Wis. 67; French v. Fidelity & Casualty Co., 135 Wis. 259.

The law of some of the states still and of some other states before the enactment of the Standard Provisions Law might be construed to authorize contracts promoting specific benefits for specifically described bodily losses and physical disabilities. When this fact is considered in connection with the further fact that the courts have been sadly lacking in a knowledge of the principles of insurance and secured no help from attorneys, the inconsistencies in the decisions are explained and the decisions where such lack of knowledge of insurance is manifest lose their force and value.

Accident and disease as causes of the loss insured against in these health and accident contracts were carefully distinguished and differentiated. The term "accident" was given a technical meaning and distinguished from the general term. In a general way, the technical term had the element of means exterior to the body of the insured and the additional element of force or violence. Disease as a cause of disability was held to originate within the body, or, if originating outside of the body, was by means not appreciable to the senses. Kelsey v. Continental Casualty Co., 8 L. R. A. (N. S.) 1014 and note; Berry v. United Commercial Travelers, 1916B L. R. A. 617, and annotation; Fidelity & Casualty Co. v. Johnson, 30 L. R. A. 206, and note.

### What Losses Included in Contracts

When policy forms were practically unregulated by statute law, and were so formulated that some clause or provision could be invoked upon which liability might be

denied or the indemnity reduced to almost nothing, the courts, in order to construe the contracts as designed to provide real insurance, indulged in the most sophistical and specious refinements of reasoning to eliminate inequitable limitations and restrictions from the contracts and to import terms or phrases on which to base a recovery. The loss of feet was construed to mean the loss of the use of the feet; self destruction by an insane person was held to be due to accidental means; a dead body was held to be a visible mark of an accident on the body of the insured; the limitations on the term "accident" were disregarded and a policy was held to include unanticipated or unexpected results of causes which were not accidents; death by inhaling gas was held due to external and violent means; and so forth almost endlessly. Cases were treated individually, and a recovery and the amount of a recovery in the courts were limited only by the subtlety of the courts. Despite the attitude of the courts the insurers continued to reject and reduce claims most unjustly.

### National Convention of Commissioners in 1911

The scandal arising from the settlements of health and accident claims was finally taken under consideration by the National Convention of Commissioners.

A committee was appointed to examine settlements and report to the convention. The committee gave particular attention to the settlements of death claims, although the percentage of such claims of those examined was small. The committee did not consider policy forms and provisions from the legal, equitable, or insurance standpoint, but judged the settlements by a literal application of the policies and provisions to the facts of the cases; that is, they applied the policies as construed by the insurer. Even under such a construction of the policies, the committee found that grossly unjust advantage was taken of claimants by some of the insurers. Notices of claims

were disregarded or liability was arbitrarily denied regardless of policy provisions. Claims were reduced and prorated on false grounds, and were prorated two and three times. Policies were suppressed and secured from prospective claimants by crooked practices, so claims could not be presented. Accumulations and double indemnities were concealed or denied. Suits were protracted by dilatory tactics. When advantageous to the insurer, specific indemnities were construed as indemnity for loss of time, and when advantageous to the insurer were construed as the valued benefit for a specific bodily loss without any relation to loss of time. Surgical and medical benefits provided in the policies were ignored. Claims were adjusted without the actual loss sustained by claimants being ascertained and given consideration, but on the theory that there was no liability unless a specific bodily loss or disability, carefully defined and described and limited and restricted, had been sustained. In the partial report of the committee made in 1911 prior to the completion of the examinations, the committee obviously appreciated that the inequities brought to light by the examinations were due largely to the involved, technical, ambiguous, complicated, and inapplicable policies being issued, which were not formulated to provide insurance, but were designed primarily to evade court constructions and were used by many of the so-called insurers to reject and reduce claims. The committee, therefore, recommended legislation which would require policies to insure against loss from all accidents and all illnesses except such as the experience of the insurers had shown they should not insure against. The committee reported:

> "The experience of the companies in this field is now sufficient so that they ought to know what risks, either of illness or accident, they should not insure against. The policyholder should be insured in full or not insured at all. The clauses in question (the one-fifth, one-tenth and similar clauses), while in

some cases intended to give the insured something rather than nothing, are usually availed of to force settlements and to fight suits."

On the matter of the amount of insurance provided by a policy the committee recommended legislation which would permit of prorating downward only in cases of actual change of occupation, which would provide for prorating upward when equity would so require, and which would prohibit double and triple prorating. The obvious effect of the adoption of the concrete recommendations of the committee would be the execution of the general purpose to make indemnity for loss the basic element in these policies.

The only other primary recommendation of the committee for legislation which might affect the character and form of the policy, was the recommendation that the ignoring or denial of liability on an accumulation or double indemnity provision in a policy should subject the insurer to punitory damages for double the benefits so ignored or denied. Manifestly, this recommendation was designed to prevent fraud and deceit on the part of the insurer. The committee also recommended legislation which would make the application a more vital factor of a policy. While the investigations of settlements were in progress, Workmen's Compensation Laws had been worked out on a scientific basis and enacted in several of the states. The committee had the benefit of the work done in the preparation of these laws and obviously availed itself thereof in making its final report.

The final report of the committee of the Commissioners' Convention was made in 1912. Conformably with a resolution, adopted unanimously at the time the committee made its partial report, directing the committee to "continue its investigation both into the facts and of proposed remedies and when such investigation is, in its judgment, substantially completed, such committee prepare the draft of a proposed uniform bill that will carry

out its conclusions," the committee presented a Standard Provisions Bill, governing health and accident insurance companies, perfected through the efforts of the special committee, a subcommittee, and the active cooperation and assistance of the committee of the companies operating in this field. The report was unanimously approved by the Commissioners' Convention and has been enacted in more than thirty of the states as the Standard Provisions Law.

It is only fair to state that the investigation disclosed that many of the insurers appreciated that the primary purpose of an insurer is to pay claims, and that they were restricted and thwarted in the execution of this purpose because of chaotic conditions, lack of system and regulation in the business, and especially because of unfair and vicious competition.

### Standard Provisions Law

The manifest purpose of the law was to provide rules and regulations for formulating standard forms of policies which should be adaptable to all individuals as to the amount of insurance provided, as to the perils or risks covered, and as to the kinds of losses for which indemnity might be provided.

The requirement of the law that a schedule of premium rates and a classification of risks be filed with the department with each policy form is evidence of a purpose to make each form of policy adaptable to every individual; that portion of the law providing for exceptions from a policy is evidence of a purpose to make the cause of loss determinative of liability; and the provisions of the law with respect to the character of the losses for which indemnity might be provided and paid is evidence of a purpose to classify indemnity.

The law not only regulates and prescribes the forms of policies but through the Standard Provisions prescribes the procedure to be followed in the settlement of

claims. The purpose back of the law was to introduce order and system into this branch of insurance which, theretofore, was a veritable chaos. This purpose is evidenced not only from the affirmative mandatory requirements and regulations of the forms of policies, but is emphasized by the provisions of the law as to forms which might be issued not complying with the law. Subsection (9) provides:

> "*Other forms valid.* A policy issued in violation of this act shall be held valid but shall be construed as provided in this act and when any provision in such policy is in conflict with any provision of this act the rights, duties and obligations of the insurer, the policyholder and the beneficiary shall be governed by the provisions of this act."

Obviously, a policy not formulated in harmony with all of the regulations and restrictions of the act would be issued in violation of the act. A policy not providing the kinds of indemnities classified in the act, and not providing that the losses shall be due to the causes mentioned in the act is in violation of the act.

The law standardizes health and accident policy forms, although the phraseology for the different forms of policies contemplated and authorized and the combination of these forms is not definitely prescribed. No attempt is made in the law definitely to fix the amount of indemnities or the premiums, or to make a definite classification of risks, except that the law provides by implication that a classification of risks must be based on occupation, for under no other classification can the insurer, under the law, obtain larger premiums from more hazardous risks or reduce the benefits on settlements of claims.

The Standard Provisions Law radically limits the kind of health and accident policies which may be issued. Based on the classification of indemnities the kinds of policies providing insurance against loss by accident are limited to three, loss of life, loss of time and loss other

than that of time, and the policies providing insurance against loss from sickness are limited to two, loss of time and loss other than that of time. By the provision of the law permitting exceptions from a policy the number of different forms of policies, i. e. different kinds of insurance, which may be formulated under the law is unlimited but none of the insurers apparently have appreciated that limited policies might be formulated under the law. The almost invariable practice when formulating limited policies is to enumerate the specific indemnities and to make few exceptions of accidents and diseases. The limit on the number of forms of policies arises out of the regulations which the law makes of the requisite elements of these contracts, and the interrelation of the different elements by reason of the regulations. In the case of Williams vs. Travelers Ins. Co., 168 Wis. 456, the court says:

> "When the legislature declares, as it has by this section in question (Section 1960, Standard Provisions Law), the public policy of the state to be that that which had theretofore been subject to contract between the parties shall hereafter be by certain prescribed forms and with specific conditions concerning the respective rights and duties of the parties thereto, the statutory provisions step in and control and regulate the mutual rights and obligations rather than the provisions of any contract the parties may attempt to make varying therefrom."

Unless the Standard Provisions Law be construed to authorize only the forms of policies described and regulated and to prohibit all forms to which all of the provisions of the law are not applicable, the observance of the law and the force and effect of the Standard Provisions become optional with the insurers. If they desire, they will formulate policies under the law and give it effect. If they please, they will formulate policies on any theory they choose and ignore the law with the observation that it does not apply to the policies as formulated

Every contract under the law must comply with definite restrictions and regulations made in the law. Policies issued to certain groups, certain policies supplemental to life policies, and policies or certificates issued by fraternal benefit societies, are excepted under certain conditions from the operation of the act. Certain railroad ticket policies are excepted from certain portions of the act. Construing the Standard Provisions Law under the classification of the requisites of insurance contracts in Joyce on Insurance, Section 43, the law regulates such contracts as follows:

1. *Parties thereto.* No more than one person shall be insured in a contract.

2. *The premium.* The law requires that premium rates for each policy form formulated by an insurer shall be filed with the department of insurance. This regulation is designed to prevent discrimination between insurants in the premium charged. Considered in connection with the requirement that a classification of risks shall be filed with each policy, the law requires that every policy issued shall be adaptable to every individual.

3. *The subject matter.* The insurance regulated by this law is defined in subsection 1, as "insurance against loss or damage from the sickness, or the bodily injury or death of the insured by accident." Indemnity for loss is the subject matter of every contract of insurance. In various parts of the law and the Standard Provisions, the subject matter of the different contracts authorized is defined and classified into "indemnity for loss of life," "indemnity for loss of time," and "indemnity for loss other than that of time." The distinction between contracts of indemnity and contracts providing valued benefits for specifically described bodily losses and disabilities is essential if the Standard Provisions Law is to be of any force or effect.

4. *An insurable interest.* The Standard Provisions provide for the payment of the indemnity for loss

of life to the beneficiary or the estate of the insured, and for the payment of other indemnities to the insured. Obviously, although there is no specific provision to that effect, the general law of insurance on this element of insurance contracts is incorporated in the Standard Provisions Law.

5. *Certain perils or risks.* The law names "sickness" and "accident" as the perils or risks which cause the loss or damage for which indemnity may be paid under these contracts. These terms are not used in the law to avoid an enumeration of all diseases and all accidents, but are used to define and describe the risks or perils which may cause the loss or damage which is the subject matter of the contracts. The terms are general ones and are inclusive and exclusive. The differentiation of these terms made by the court decisions and the technical definition of the term "accident" for this branch of insurance made before the enactment of the law are, of course, incorporated in the law. If these terms be not used as general terms and considered and applied apart from any particular disease or accident, the committee of the Commissioners' Convention did not follow its own recommendations and the provisions of the law providing for exceptions from a policy and prohibiting any reduction of the indemnity have no force or meaning.

6. *Duration of the risk.* The law has a specific regulation of the element of the duration of the risk, in that it provides that the time when the insurance takes effect and terminates must be stated in the policy.

7. *The amount insured.* A policy of insurance must have an amount of insurance. There are several provisions in the Standard Provisions Law authorizing a reduction of the amount of indemnity. The regulations of the law in these provisions would be without force *if every contract does not provide a definite amount of insurance for each kind of indemnity provided.*

The proviso to subdivision (6) of subsection (2) requires that "any portion of such policy which purports, by reason of the circumstances under which a loss is incurred to reduce any indemnity promised therein to an amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed in bold face type and with greater prominence than any other portion of the text of the policy." The law elsewhere, as hereinafter noted, makes provision for a reduction of the indemnity in case of the ordinary risk.

The question arises as to what circumstances affecting the amount of indemnity provided by a contract justify a reduction of the benefits; or what circumstances affecting the amount of indemnity, if not effecting a reduction of the indemnity, would require under a contract the payment of benefits in excess of indemnity. Otherwise stated, the question is, what circumstances affecting the indemnity or amount of insurance provided in a contract make a risk substandard. The limitations in the question require that a substandard risk be defined as one who has already sustained a bodily injury or loss, or who is afflicted with some disease which has decreased the amount of loss he may sustain, or which in the event of other bodily losses or disabilities affecting him, will have suffered at such time a loss greater than would be sustained by the ordinary risk. For example, a person who has suffered the loss of one eye cannot perform work which requires the use of two eyes; a person who has suffered the loss of his right eye, in losing his left eye will be totally disabled, while the ordinary risk in suffering the loss of his left eye will be only partially disabled; existing neuritis in the right arm, combined with an injury to the left arm will totally disable a substandard risk while the injury will only partially disable the ordinary risk. The fact that nowhere else in the law is provision made for the insurance of risks substandard as to the amount of loss which may be suffered, and the fact

that the law covers the whole subject, are conclusive on the construction of this proviso. The law makes provision against over-insurance and the payment of benefits in excess of indemnity for the ordinary standard risk as follows:

Subdivision (2) of subsection (4) prohibits any provision in a contract "limiting the amount of indemnity to a sum less than the amount stated in the policy" unless it be in the form of one of the Optional Standard Provisions. Obviously, this clause of the law would be meaningless unless a policy provides a certain amount of indemnity for each kind of indemnity contemplated by the law. Optional Standard Provision No. 17 provides for a reduction of the indemnity provided in a contract if the insured shall carry with another insurer other insurance covering the same loss without having given written notice of such other insurance to the insurer. Optional Standard Provision No. 19 provides for the reduction of the amount of insurance carried by an insured in two or more policies with the same insurer to the limit stated in this provision. If Optional Standard Provision No. 17 and No. 19 be used in a policy they should be printed in bold face type to comply with the proviso to subdivision (6) of subsection (2).

Under one form of Standard Provision No. 1, the indemnity may be reduced if there be a change of occupation to one more hazardous than that stated in the policy. This provision, if used, should be printed in bold face type to comply with the proviso to subdivision (6) of subsection (2).

### Essentials of Insurance from the Social Standpoint which are Conditions Precedent to a Contract of Insurance

Without attempting to discuss them, or to make application of them to specific cases, I desire at this point to set out some of the essentials of insurance from the social standpoint which are conditions precedent to a con-

tract of insurance; i. e. a policy of insurance. These fundamentals are of necessity, basic to and incorporated in the Standard Provisions Law.

1. The institution of society.
   a. Individual ownership of property.
   b. The right of the individual to the product of his labor and foresight and to make disposition of the same.
2. A cause accidental in its nature producing destruction or damage to value or goods actual or potential.
3. Losses sustained by individuals must be so spread as to affect society or a group of society and cause a social loss.
4. Valuation of loss must be social and loss of individuals so valued must be capable of determination.
5. Purpose in the individuals liable to suffer loss, to protect themselves against economic annihilation, and the creation from this purpose of a group to bear the losses of individuals.
6. Individual hazard must be measurable and loss must be capable of distribution.
7. Cause of loss must be accidental as to individual risks.
8. Accumulated data sufficient to enable prediction of the approximate amount of loss which will be suffered by the group.

In the practical operation of an insurance business the essentials of insurance are of varying importance, depending on the character of the insurance, and the ease or difficulty with which the necessary data may be collected and collated. Obviously, the extent to which such collection and arrangement of data have been carried depend upon the degree to which the business has been depending on the character of the insurance, and the ease is measured quite closely and evidenced by the degree to which the statutory law regulates the details of such branch, and the completeness with which fundamental principles have been formulated for use in such branch

Thus in life insurance we have in the mortality tables a scientific classification of risks, and the business is regulated by the statutes, notably, in the detail of the amount of expense charges which may be made. In fire insurance we have in considerable degree the regulation of rates. In workmen's compensation insurance six years is the limit of insurance for loss of time and the percentages which certain specific bodily losses and disabilities bear to total loss, and the amount of insurance to be provided by such contracts have been definitely fixed by statutes, etc. In health and accident insurance, the law does not limit the amount of insurance to be provided, does not establish rates or a detailed classification of risks, nor fix any relation of expense to premium, nor of definite bodily losses or disabilities to the amount of insurance provided, but by the Standard Provisions Law the matter of the settlement of claims is regulated with much detail, and the form and provisions of the policies is standardized by the recognition of principles of peculiar importance in this branch of insurance which are calculated to promote the growth and development of this business.

## Principles of Insurance Specifically Recognized in the Standard Provisions Law

### *Indemnity*

Insurance in its broadest conception is a method of distributing through a group the losses of individuals, due to certain accidents or contingencies which are determinative of the character of the insurance. "Insurance is cooperative provision against individual losses."

Obviously, the benefits received under an insurance contract by one who has suffered loss are limited to the amount of loss, which would be indemnity in full. Profit from an insurance contract is, therefore, foreign to insurance. Instead of profit, loss to the policyholder is a prerequisite to an insurance contract, for the payment of a premium or an agreement to meet assessments to pay

losses is prerequisite to membership in the group, and the acquisition of the right to receive indemnity for a much greater loss liable to be suffered by each individual. That indemnity in whole or in part, and indemnity only, is a prerequisite of insurance, because profit is foreign to insurance, is axiomatic, but in practice it is sometimes disregarded, because the amount of insurance provided under any circumstances can only give benefits of less than indemnity. In life insurance this principle of indemnity is largely disregarded because the ordinary risk is unable to pay the premium for an amount of insurance which would fully indemnify for loss of life; i. e. loss of future earnings. Because of this fact and the further fact that life insurance in practice has a large investment element, some of the courts have been misled into saying that a contract of life insurance is not a contract of indemnity, but the limitation, which the courts have sustained, contained in some of the life policies as to the amount of insurance which might be carried by a risk, are a recognition of the principle.

In health and accident insurance, from the standpoint of indemnity, the maximum loss which is liable to occur is in excess of that which follows loss of life, for an insured may be totally and permanently disabled and suffer not only a loss of all future earnings, but also be obliged to meet expenses for care and medical treatment. The premium to provide indemnity in full would, therefore, be prohibitive. But no limited amount of insurance or indemnity has been recognized and adopted as in life insurance as the basis for the calculation of premiums even for loss of life by accident.

The principle of indemnity as basic to insurance may be disregarded when every loss is a total loss and when the amount of insurance which is provided and can be carried is less than indemnity, but when, as in health and accident insurance, a total loss is relatively rare, and practically all of the losses are partial, the principle of

indemnity and indemnity only becomes of especial and controlling importance for the making of insurance contracts. Instead of emphasizing the principle of indemnity, the health and accident insurers have formulated contracts on the assumption that every loss was a total loss, and that the only limitation on the benefit to be paid was the amount stipulated in the contract for each specific loss, and so far as the insured was concerned, the only limitation on the amount of a benefit was the ability to pay the premium asked for an amount of benefit for a definitely described disability or bodily loss.

The disregard of indemnity as basic to health and accident insurance has been further emphasized by the insurers in formulating their contracts, by the failure to distinguish the loss itself for which indemnity would be paid, from the cause of the loss; i. e. personal accident and sickness. The law does not permit the payment of indemnity for loss of life from disease, but many of the present policies provide benefits as for a total loss resulting from certain diseases, notably sunstroke and freezing, and on the other hand attempt to relieve the insurer from liability for loss from accident if the accident results in specific diseases; for instance, hernia or septicaemia. Personal accident and health insurance are thus confused with life insurance, apparently because of a failure to appreciate that premature death is the cause of loss in life insurance, while in personal accident insurance, death is the *loss itself* for which a valued benefit is to be paid.

Confusion and ambiguity of another sort are injected into the contracts by the failure of the insurers to appreciate the fundamental character of indemnity to health and accident insurance through their omission to distinguish and differentiate indemnity from the amount of insurance provided by a contract. Indemnity in full cannot be furnished because the cost would be prohibitive, but the amount of insurance represented as provided in

the policies now being issued is greatly in excess of the amount of insurance actually given, and is fixed regardless of the fact that the only limit to the indemnity for partial loss, in the absence of coinsurance by self-insurance, is the amount of insurance provided by a contract. The law does not authorize self-insurance in health and accident insurance policies. On the contrary, any provision reducing the indemnity stated in a policy is prohibited, with the result that a claimant under an accident or health policy is entitled to full indemnity for partial loss up to the amount of insurance provided by the contract. Ignorantly, or by reason of the faulty forms of the policies of the other insurers, each insurer disregards the principle that a claimant is entitled to full indemnity for partial loss to the limit of insurance provided in the contract, disregards the fact that the principle is liable to be applied by the courts, and condemns the courts when the principle is applied.

Perhaps the greatest source of confusion with respect to the amount of indemnity provided by health and accident contracts arises from the failure of the insurers in formulating contracts to differentiate the different kinds or classes of indemnity provided. The most general classification of indemnity in health and accident insurance is into indemnity for loss of life and indemnity for loss other than that of life. Since indemnity for loss of life cannot be provided under the law in a health contract, in a combination health and accident contract, personal accident indemnities and sickness indemnities must be differentiated. Indemnity for loss other than that of life may naturally and logically be classified into indemnity for loss of time and indemnity for loss other than that of time, and this is the classification recognized by the law. Indemnity for loss of time might be subclassified or grouped into specific indemnities for specific bodily losses or disabilities (as is done by the workmen's compensation acts), and specific indemnities for specific

degrees of disability, and indemnity for loss other than that of time might be classified into indemnity for expenses of medical attendance, hospital expenses, nursing expenses, medical appliances, etc., but the law does not make or authorize such sub-classifications, and under subsection (9) of the Standard Provisions Law, they must be held ineffectual. This failure of the formulators of health and accident contracts to take the principle of indemnity into consideration has resulted in contracts which literally construed are nothing more or less than gambling contracts, and are nothing but bets between the so-called insurer and the individual policyholders, whereby the insured bets a small sum that he will suffer some one of the limited number of specifically described bodily losses or physicial disabilities and the insurer bets a larger sum that he will not.

### *Specifically Described Bodily Loss or Disability not Contemplated*

The term "indemnity" or its plural, occurs thirty times in the Standard Provisions Law and the Standard Provisions. The term "benefits" occurs once as a synonym for "amounts of insurance." Since the law regulates all health and accident contracts and excepts certain policies from the operation of the law, it is evident that the Standard Provisions Law contemplates and authorizes only contracts of indemnity, and it is clear that the law does not contemplate a contract not based on indemnity. The omission from the law of any regulation of a benefit not based on indemnity, or any rules for the settlement of claims not based on indemnity, is conclusive that such benefits and such claims are not contemplated. A contract not based on indemnity would be issued in violation of the law. The law mentions, and by providing in various places certain procedure for the settlement of claims, classifies indemnity into "indemnity for loss of life," "indemnity for loss of time," and

"indemnity for loss other than that of time." Nowhere in the law or the Standard Provisions is there a term or a phrase used which may, when construed with the other provisions of the law, reasonably be construed to contemplate a contract providing a valued benefit for loss of limb, loss of sight, disability which confines to the house or requires the attendance of a physician, etc., or any other specifically described bodily loss or disability.

Literally construed, the present policy forms provide specific or valued benefits for specifically described bodily losses and disabilities regardless of the cause of loss and irrespective of the amount of loss. These are not the contracts contemplated by the Standard Provisions Law. Only the person who knows what particular loss or what specific disability he is liable to suffer receives protection and is entitled to benefits under such policies. The normal risk receives benefits based on his loss only contingently, that is, when an accident or a disease takes a course which has been predetermined by the insurer. The law contemplates contracts which will provide indemnity for the ordinary normal risk for loss suffered up to the amount of insurance provided, because of the happening of the contingency causing loss. The law does not contemplate or authorize contracts which provide a specific benefit for a specific bodily loss or disability, irrespective of the cause of the loss and regardless of the amount of the loss.

If insurance against specific bodily disabilities or losses from accident or disease is not authorized by the law, and the law regulates the whole subject of insurance against loss because of bodily disability from accident and disease, insurance against only those kinds or classes of losses specifically mentioned in the law may be provided. The law mentions only indemnity for loss of life from accident, indemnity for loss of time from accident or sickness, and indemnity for loss other than that of time from accident or sickness. The conclusion is inevi-

table that the law does not authorize contracts against specific bodily losses or disabilities and in fact prohibits such contracts. Under the law, therefore, such provisions for specific benefits must be considered as eliminated from the contracts and they are effective only as offers of settlement.

The prerequisites of insurance are essential to the construction of insurance contracts which are the tangible evidence of the agreements. The key to the differentiation of the policy form submitted from the policy forms now issued by health and accident insurers lies in the fact that in the preparation of the form submitted, the principle of indemnity, which is mentioned and recognized many times in the Standard Provisions Law and the Standard Provisions, and which is fundamental to all insurance, has been kept constantly in mind. This principle has also been applied as a test to the policy forms now being issued and the failure of these policies and the provisions to meet the test has been the cause of their condemnation. These provisions in the present forms, however, have one element of insurance contracts which is carefully regulated by the law and that is the amount of insurance provided by a contract. It is not necessary to elaborate on the risk an insurer is running from having these provisions in its contracts and of having the contracts construed adversely to the insurer with respect to the amount of insurance provided.

### *Loss Must be Measurable*

Closely related to the principles of indemnity and basic to the operation of that principle are the essential conditions precedent to a contract of insurance that the amount of loss sustained must be capable of determination and that the valuation of the loss must be social. The loss for which indemnity is to be paid must be measurable in money and must be a loss which affects society. These conditions are of peculiar importance in *health and acci-*

*dent insurance* because of the difficulty of securing a satisfactory measure of loss and the necessity of differentiating the individual value of the loss from the economic loss to society. Physical pain and mental suffering cannot be used to measure the amount of indemnity for disability. Nor can groans or tears, the evidence of suffering, loss of sight or hearing, a crippled or disfigured body, measure indemnity, for the normal human being values health and a perfect body above any amount of money, and the abnormals, who would endure pain for a money consideration, have each an individual opinion as to the amount of money which would compensate for any specific kind of pain or bodily loss.

The Standard Provisions Law recognizes the difficulty of securing a satisfactory measure of the loss suffered because of disability from personal accident and disease by the provisions calculated to limit the amount of insurance to indemnity and by those provisions designed to provide for the ascertainment of the actual loss. By the recognition of time as the measure of loss because of disability and by the differentiation of loss of time from loss other than that of time, the law provides for the ascertainment of the actual loss, eliminates from the business, except in case of loss of life, the valued benefit and with the valued benefit the individual valuation of bodily losses or disabilities, and recognizes that indemnity can only be given for loss which is economic and social. Pain and suffering are thus eliminated as measures of the amount of indemnity. Loss of time is limited to loss of income due to disability, and loss other than that of time is limited to and includes expenses necessarily incurred because of bodily disability. Because the Standard Provisions Law contemplates only the payment of benefits based on indemnity and provides the measure to be used for ascertaining the amount of loss, the amount of insurance provided by a policy, for any kind of indemnity contemplated and authorized by the law, may be definitely

fixed and the policies simplified and freed from ambiguity in this respect. It would be tautological to say that present health and accident policies are not in harmony with the law as to the amount of insurance provided by them. Even under the general law of contracts, the obligations of a contract must be definite and clear. In the policy submitted for criticism and suggestions, the amount of liability is definite and certain, and the obligation is to indemnity for loss up to a definite amount if *death* be due to *accident;* to indemnify for loss up to a definite amount if *loss of time* be due to *accident;* to indemnify up to a definite amount if *loss of time* be due to *disease;* and to indemnify up to a definite amount if *loss other than that of time* be due to *accident* or *disease.*

*Premium Rates and Classification of Risks*

The Standard Provisions Law requires the filing of a classification of risks and premium rates pertaining thereto with each policy form filed with the department. This requirement of the law is a recognition of the principles of insurance that a loss to be the subject of insurance must be measurable and capable of equitable apportionment through the group of the insured. That a loss must be measurable is a corollary to the maxim that indemnity and indemnity only is basic to insurance. The requirement that premium rates shall be filed is a recognition of the principle that the losses of individuals must be capable of equitable distribution. The classification of risks and the premium rates become part of a policy under the law. Since this investigation is limited to the forms of the policies under the law, the matter of premium rates and of a classification of risks will not be exhaustively considered. It is fitting, however, to note that the classifications of risks and the schedules of premium rates filed with this department are not made up as contemplated by the law; also, to make some general observations on how a classification of risks and a schedule of premium rates should be arrived at under the law.

Loss of life by accident is ordinarily treated as a benefit in lieu of the benefit for loss of time, and it is assumed that the premium is comprehended in the premium for loss of time. The amount of insurance provided in combination health and accident policies for loss of time from accident almost invariably is larger than the amount of insurance for loss of time from sickness; i. e., the weekly or monthly indemnity is payable for a longer period. Claims for loss of time from sickness have not been and are not adjusted according to the time lost by the insured but generally no benefits at all are paid unless there be total disability to perform any and every duty pertaining to the duties of claimant's occupation. Full indemnity as limited by the policy as the amount payable weekly or monthly is generally only paid if the total disability be accompanied by confinement to the house and the regular attendance of a physician, and if the total disability be continuous. Partial indemnity, usually one-half, is generally only paid in cases of total disability. House confinement is not required but the attendance of a physician is a customary requirement. The value of the time lost, whether total or partial, is not taken into consideration in adjusting such claims.

Claims for loss of time from accident are generally rejected unless disability be immediate on the accident. Partial indemnity, usually one-half, is paid if there be disability to perform a material part of the duties of the insured's occupation. If an accident results within ninety days in one of the specific losses listed in the schedule of a policy the amount provided in the schedule is paid. The actual loss of time suffered and the unaccrued indemnity for loss of time to which a claimant would become entitled is not considered in the settlement of such a claim. The principal sum of a policy on which the specific benefits for specific bodily losses are calculated is usually less than the amount of the benefit for loss of time to which the insured would be entitled. For instance, taking into

consideration the expectancy of life a claiment would be entitled to $15,000 for loss of time because of the loss of the sight of both eyes. The claim would be adjusted by the insurer on the assumption that there was no liability for loss of time and the benefit provided in the policy for the specific loss of sight of both eyes was a valued benefit and the limit of liability. Insofar as a relation between the amount of insurance provided by present policies and the premium charged for them is recognized, therefore, the relation is between the specific benefits for certain bodily losses and certain specifically described losses of time and the premium charged; i. e., the cost to the insurer and the premium. The classification of risks may be assumed to have been made by classifying the costs of specific benefits according to occupations and the premiums charged in the various occupations would therefore be percentages of the amounts of the costs to the insurers in the occupations. As a matter of fact the classifications of risks practically have been guesses based on the opinions of the insurers. The present classifications are the collated guesses of the various insurers modified in a few instances by tests as to certain occupations.

*How to Obtain a Premium*

A premium is the cost of a definite amount of insurance for a definite period plus the expenses of administration.

The cost of insurance is obtained by dividing the sum of the losses by the amount at risk.

The premium rate is obtained by dividing the sum of the losses plus the sum of the expenses by the amount at risk.

The premium on an individual policy is found by multiplying the amount of insurance provided in a contract, by the premium rate for a definite amount.

The law requires that such a premium rate shall be filed for indemnity for loss of life by accident, indemnity for loss of time by accident, indemnity for loss of time

from sickness, and indemnity for loss other than that of time from sickness and indemnity for loss other than that of time by accident *for each form of policy filed with the department.*

*How to Obtain a Classification of Risks*

A classification of risks in accident insurance should be obtained by grouping the losses according to occupation and finding a premium rate for each kind of indemnity for each group.

A classification of risks in health insurance should be obtained in the same way.

The premium rates so obtained for every group would constitute the schedule of premium rates to be used for prorating claims by reason of change of occupation.

The urgent need in the health and accident insurance business today is some well planned method of collecting and collating the data to obtain the cost of insurance. It is obvious that the present methods of conducting the business with no common basis for ascertaining such data cannot furnish them.

A refinement of the schedule of premium rates which will be provided in the future will show a certain premium for a definite amount of insurance for the first week or month of loss of time and a lower premium for the succeeding weeks or months. Such a schedule will take account of the fact that the great majority of claims are only of short duration.

Since policyholders cannot pay the premium for full indemnity the problem in health and accident insurance is how equitably to meet only a part of the loss. Equitable and scientific premiums cannot be ascertained until the losses which are to be met are definitely fixed. Under present practices the indemnity for loss of time provided by the multitude of policies varies from none at all to as long as the insured shall live. "As long as the insured shall live" covers a total loss. As heretofore stated health and accident policyholders cannot pay the premiums to

provide full indemnity. It is evident, therefore, unless the policies providing indemnity in full are deceptive and based in fraud, that those entitled to indemnity for the shorter periods must contribute more than their equitable share to meet losses. In other words, the holders of policies providing full indemnity do not pay adequate premiums. In health and accident insurance except in case of accidental death, indemnity has two elements; namely, loss of time and expense incident to the case of the person of the insured. *The problem in health and accident insurance is to provide full indemnity in cases of partial loss of time and substantially full indemnity in cases of total loss of time for a limited period of time.* The solution of the problem of equitable and scientific rates in health and accident insurance lies in the determination of a just and reasonable limit to the time for which indemnity will be paid. In the workmen's compensation acts the period is fixed at six years. There is no hope that a period will be fixed in the accident and health insurance business by agreement of the insurers. The only effective alternative is through legislation. The Standard Provisions Law should be amended to prohibit a provision in a policy for the payment of indemnity for a longer period than five or six years. A limitation of this kind is a prerequisite to the determination of scientific premium rates and the solution of the problem of how to provide indemnity for loss of time. The cost of insurance against death by accident has been worked out by actuaries for life insurance companies. Either the health and accident insurers should use the premiums so worked out or they should abandon this branch of the business. Data are available in connection with the administration of the compensation acts which will give the cost of insurance to provide indemnity for loss other than that of time due to accident. These data should be used and the data on cost of insurance for loss other than that of time for sickness should be gathered to

the end that the premium for this indemnity might be ascertained and the business in this respect be put on a firm foundation.

In a well organized and systemized insurance business, such as obviously is contemplated by the law, the cost of insurance is the chief factor of a premium and the charge for expense is incidental. In the health and accident business today, the charge for expenses is the chief factor of the premium, and the cost of insurance (the benefits paid, being about 40% of the premiums), is the incidental factor. Not only is the relation of cost of insurance to expenses the reverse of what it should be, but the cost of insurance is not the cost of insurance for the indemnities authorized by the Standard Provisions Law. The cost of insurance is the cost to the insurers of the specific indemnities provided in the policies as construed by the insurers before the investigation of the commissioners in 1911 and the enactment of the Standard Provisions Law. The classifications of risks have also been determined by the cost to the insurer of specific indemnities for specific losses, regardless of the actual loss suffered in occupations for which the policies are presumed under the law to provide indemnities. The costs so determined have been increased or decreased by mere guesses and opinions originating in exposures, age, occupation, sex, race, etc.

For instance, the premium rate for loss of time and for loss other than that of time for miners is determined largely from the fact that the death rate from accident is high. Manifestly, instead of increasing the rate for loss of time and loss other than that of time, a high death rate would tend to decrease the rate for these losses.

The result of this procedure has been practically the determination of premium rates for individuals without a spread of risks sufficient to give averages of any value. The amounts of the rates so determined have been used as the basis for making classes. Obviously, the premium

rates and the classifications of risks so arrived at are not based on occupation and the kind of indemnities contemplated by the law. As heretofore noted, the premium rates and the classifications of risks so determined are only incidentally related to the present investigation, but the provisions of the law on them are a recognition of certain insurance principles.

It is axiomatic in insurance that the premium for any kind of insurance is directly related to the amount of insurance provided. The character of insurance is determined by the nature of the contingency which causes the loss for which indemnity is to be paid. The kinds of accident insurance and the kinds of health insurance which may be provided are limited only by the number of accidents and combinations of accidents which may be excepted from a full coverage and the number of diseases and combinations of diseases which may be excepted from the full health coverage. Each of the kinds of insurance so determined would differ from every other in the liability to meet with a definite amount of loss and the premiums for a like amount of insurance should differ according to the liability to meet with this loss. For example, if one policy covers loss due to aviation accidents while in another policy such accidents are excepted the hazard of loss from the policy covering such accidents is greater than under the other form. The Standard Provisions Law contemplates that where the hazard of loss varies under a policy by reason of occupation that the amount of insurance provided for a certain premium shall be determined by the classification of risks filed with the policy. It also contemplates that where the liability of loss varies by reason of differences in the character of the insurance provided by different policies that the insurer shall file a separate schedule of premium rates and a separate and distinct classification of risks for each form of policy. And the law also contemplates that where the hazard of loss varies by reason of factors

not due to occupation or the character of the insurance, for instance, sex, age, race, etc., that the insurer shall be protected against overinsurance by the exercise of care in the operation of the business in its own organization.

### Description of Present Policy Forms

In order that the policy forms being used may be considered in connection with the regulations of the law, and may be compared and contrasted with the revision of the form of policy submitted for criticisms and suggestions, the description of present health and accident policy forms contained in Special Report VI of the report of the Health Insurance Commission of the State of Illinois is herewith presented. The policies issued in Wisconsin are practically the same.

*"Policy Contracts Used by Casualty Companies.*

"Three kinds of policies are used by casualty companies in selling health and accident insurance: health policies, accident policies, and combination health and accident policies. Each of the first two classes, as the names indicate, provides only the kind of insurance named; the combination health and accident policies insure the policyholder in one contract against both accident and sickness. Some companies write all three kinds of policies; others issue only the combination contracts.

"The health and accident policies of the casualty companies are also classified as "commercial" and "industrial." Commercial policies commonly provide *weekly* benefits to compensate for loss of time from disability due to sickness or accident, as the case may be, ranging from $10 to $50 or more and other benefits which are correspondingly high, and are usually sold on the annual premium plan. Industrial policies provide smaller benefits, ranging from $20 to $125 *per month* for disability resulting from accident or disease, and are usually sold on the monthly premium plan, although some are purchased by quarterly and many by *weekly* premiums. The commercial policies are designed to meet the needs and preferences of business and professional men

and the better-paid salaried employes. The industrial policies, as the name suggests, are intended to attract wage-earners.

*"Benefits Promised in Health Insurance Contracts.*

"The health insurance policies formerly sold by casualty companies insured against disability resulting from only a limited number of diseases, which were enumerated in the policy, but contracts which insure against nearly all diseases are now sold by most companies. The diseases most commonly excluded are diseases 'contracted' * * * 'while the insured is engaged in military or naval services,' diseases caused by accidental injuries, disease 'contracted and suffered without the limits of the United States, Canada and Europe,' or diseases contracted within the tropics or within certain parts of them, as the Philippine Islands or the Panama Canal Zone, and diseases contracted in Alaska and 'the British possessions in America north of the 55th degree of North Latitude,' 'sickness resulting from the use of intoxicants, or narcotics,' 'any illness not common to both sexes,' any 'sickness for which the insured is not regularly treated by a legally qualified and registered physician' and venereal diseases. Some policies contain only the restriction against venereal diseases; few if any of the policies offered for sale in Illinois contain all of the restrictions enumerated above.

"Although most health insurance contracts issued in Illinois by casualty companies cover many and frequently nearly all diseases, there is some sale in the State of a type of contract which covers certain specified diseases only and is therefore cheaper than the contracts which are more inclusive in their coverage. Several companies offer this 'limited sickness contract' to the public in Illinois in combination with an accident insurance contract and one company offers the contract in a separate health policy. One company insures, in the combination policy to which reference is made, against disability arising 'from any one or more of fifty diseases;' a second insures against disability resulting from any one or more of forty-two diseases; and a third insures against disa-

bility resulting from any one or more of twenty-nine diseases.

"The health insurance policies written by casualty companies provide for a number of benefits to cover money losses which occur in various ways as the result of sickness. The most important of these benefits is that for 'loss of time.' It is the object of this to indemnify the insured for the money loss which he suffers through disability which incapacitates him, wholly or partially, for the performance of the duties pertaining to the occupation upon which he depends for his livelihood. For this reason health insurance has been called 'income insurance.' The sum paid in a given case is not determined, however, by the amount of income actually lost by the insured through illness—the 'loss of time' benefit may be paid if there is no loss of income whatever—but is fixed by the terms of the policy at a definite amount per week or month regardless of the effect of the disability suffered upon the income of the insured. The only relation which prevails between the loss of time benefit provided by a given policy and the income of the insured is that the indemnity is ordinarily fixed at a figure somewhat less than that of the income. This is insisted upon by the insurance companies in order to avoid the moral hazard always present in over-insurance.

"The commercial policies most frequently sold in Illinois provide for weekly illness indemnities ranging from $25 to $50, payable for a period limited to fifty-two consecutive weeks, for total disability, or 'total loss of time,' as it is called in some policies. The industrial policies most frequently sold provide for monthly indemnities of $45 or $50 for 'total disability.' Industrial policies providing for indemnities as low as $20 per month are not uncommon, however, while some insuring payments as high as $100 or $125 per month are sold.

" 'Total disability' is usually defined in the health insurance policy as disability which 'shall continuously totally disable and prevent the insured from transacting every kind of duty pertaining to his occupation and shall necessarily and continuously confine

him in the house where he shall be regularly visited by a licensed physician' or in similar language of the same intent.

"In addition to the benefit for total disability just described most health insurance policies provide an indemnity for disability suffered during the period of convalescence (or a limited portion of it) following a totally disabling and confining sickness. The disability suffered during convalescence may be total or partial. Some policies provide indemnity for the first form of disability, usually called 'non-confining total disability' in the contract, and some provide indemnity for the second form which is commonly called 'partial disability.'

" 'Non-confining total disability' is defined as total disability which does not necessarily confine the insured to the house. In some policies payment for this kind of disability is to be made only when it is a result of the confining and totally disabling disease which it follows; in other policies payment is also to be made for 'non-confining total disability' which follows a confining and totally disabling sickness but is the result of another disease; and in still others payment is to be made for 'non-confining total disability' caused by any disease not specifically excluded whether it follows a confining and totally disabling sickness or not.

"'Partial disability' is variously defined in different policies but practically all the definitions agree in making inability to perform a greater or smaller portion of the regular duties of the occupation of the insured the test of partial disability. To illustrate, one company defines partial disability in one of its health insurance contracts as disability 'following a period of total disability * * * (which) shall continuously disable and prevent the insured from performing the duties of his occupation for at least half of his business time each day'; another company in one of its policies defines 'partial illness—disability' as disability which 'continuously prevents the assured * * * from performing any important duty pertaining to his occupation'; and a third company defines partial disability as disability, not total, which causes

the insured to suffer 'a material loss of his business time.' Partial disability benefits are promised in some policies for partial disability which does not follow a period of total disability.

"The amount of the indemnity paid per week or month for non-confining total disability and for partial disability is usually one-half of the indemnity paid for total and confining disability, although in some policies and under certain conditions a larger proportion is paid. The payment of the indemnity is limited in most commercial policies by a provision which fixes the maximum number of weeks for which indemnity may be paid on account of sickness, total and partial disability combined, or total confining disability and total non-confining disability combined at fifty-two weeks. That is to say, the maximum number of weeks for which the indemnity for partial disability or total non-confining disability may be paid is the difference between fifty-two weeks and the number of weeks for which the indemnity for total confining disability has been paid. In industrial policies the period covered by the indemnities mentioned varies somewhat more than in the case of commercial policies but most industrial policies sold in Illinois limit the total maximum length of time to be covered by the total and partial disability indemnity together to six or eight months and provide further that the partial disability indemnity or the non-confining total disability indemnity, as the case may be, shall be paid for not to exceed one or two months.

"An attempt has been made in the foregoing discussion to describe provisions governing the payment of indemnities for loss of time resulting from illness disability that are typical of the health insurance policies sold by casualty insurance companies in Illinois. No attempt has been made, or can be made within the limits prescribed for this report, to describe all of the various loss of time indemnities offered for sale in health insurance policies in the state. Some attention should be given, however, to certain loss of time benefits, other than those already mentioned, which are more or less frequently found in the health insurance policies now being sold.

"Some policies do not require that a disability suffered by the insured confine him to the house in order to entitle him to the full weekly or monthly payment for total disability but provide that the full indemnity shall be paid for total disability resulting from non-confining illnesses. A few commercial policies do not limit the payment of the weekly benefits to fifty-two weeks of continuous total disability or total and partial disability but promise the payment of one-fourth of the full weekly benefit 'as long as the insured continuously suffers' total disability from an illness, which of course may be for the remainder of his life. Some policies provide specifically that the full loss of time indemnity shall be paid if the insured is totally disabled by 'carbuncles, boils or felons' or 'carbuncles, boils, felons, abscesses, or ulcers,' to quote the longer list found in a few policies, regardless of the fact that his disability may not confine the insured to the house. Several policies promise to pay an 'indemnity for quarantine' equal to the full weekly benefit (double it in one policy) for a period not to exceed ten weeks in case the insured is quarantined by order of the 'civil authorities' because of an 'infectious or contagious disease' which he has contracted and 'by reason of said quarantine is prevented from performing any and every kind of duty pertaining to his occupation.' Finally, many of the policies restrict the payment of the usual weekly or monthly indemnity in the case of certain chronic diseases and diseases of long duration by providing that the indemnity shall be paid for only a fraction of the maximum period. Thus one industrial policy which promises the payment of a monthly illness indemnity for a maximum of six months for most diseases, restricts the payment of the indemnity to 'a period not exceeding one month in any one policy year,' in case the insured suffers total and confining disability 'by reason of rheumatism, tuberculosis, paralysis, neurasthenia, sciatica, Bright's disease, apoplexy, locomotor ataxia, cancer, neuritis, sprain or strains, lumbago, orchitis, hernia or any chronic disease.' A policy issued by another company carries a similar restriction but adds 'lame back,' vaccination, diabetes,

appendicitis, varicose veins, dementia, and insanity to the list of diseases excluded from liability for full benefit. A third policy, issued by a third company has a more liberal clause governing 'special diseases' in which the maximum period for which the weekly benefit may be paid is reduced from twelve months to six months and only four diseases—paralysis, tuberculosis, cancer and locomotor ataxia—are included.

"In addition to the benefits paid for loss of time which have just been described, many of the health insurance policies sold in Illinois promise one or more of a number of other benefits to cover money losses or money expenditures caused or necessitated by sickness. These include payments to reimburse the insured, within specified limits, for hospital expenses, the cost of surgical operations and the cost of medical attendance or of the services of a trained nurse, and payments for blindness and paralysis or other permanent disability and for funeral expenses. Of these indemnities, those for hospital expenses and surgical operations are most common; in fact, they are the only ones of those named which are included in many policies.

"The hospital benefit clause provides for the payment of a weekly or monthly indemnity in addition to the disability benefit in case the illness of the insured (usually within ninety days or three months of the beginning of the illness or the disability) necessitates his confinement in a hospital. In some policies the hospital allowance is fixed at one-half the regular weekly or monthly benefit; in others, it is made equal to the regular benefit; frequently it is made to cover the hospital charges exactly in so far as they do not exceed one-half the regular sum. The duration of the period for which the hospital allowance will be paid is limited, in different policies, to a maximum which ranges from ten to twenty-six weeks for the commercial policies and which is commonly three months for the industrial policies. In policies which also provide for the payment of specific sums for surgical operations it is often stipulated that no hospital allowance shall be paid if the insured claims the benefit of the surgical operations clause.

"The surgical operations clause usually promises the payment of a fixed amount of money, which varies according to the nature of the operation and the amount of the weekly or monthly disability benefit, in case the insured has to undergo any one of a number of specified surgical operations, as the result of the illness which has disabled him, within a specified time (usually ninty days in commercial policies) after the commencement of the illness. Sometimes, however, the surgical operations clause provides for the payment of the full cost of the operation, regardless of its nature, in so far as the cost does not exceed a certain multiple, e. g. double, the regular disability indemnity. The policies which promise the payment of surgical indemnities of fixed amounts according to the nature of the operation commonly enumerate from thirty to forty operations. Three policies stipulate that the insured shall not receive indemnity for more than one operation for any one sickness or disease; if he has to undergo more than one operation he is usually either paid for that operation for which the allowance is largest, or, which amounts to the same thing, he is given the privilege of choosing the operation for which he is to be indemnified.

"The 'medical attendance,' or 'medical treatment' clause is found more commonly in accident insurance contracts than in the health policies but some of the latter contain the clause. The clause as used in commercial health policies usually provides for the reimbursement of the insured for expenditures for the services of a physician to an amount not exceeding the weekly benefit promised in the policy, in case the insured suffers an illness which requires medical treatment or medical attendance but does not result in disability.

"A few policies provide for the payment of a limited amount to cover 'nurses' fees in lieu of the hospital allowance in cases where the insured, while suffering disability from illness, is attended by a graduate nurse although not confined in a hospital. The amount of the indemnity is usually subject to the same limitations as the amount of the hospital indemnity.

"Next to the allowances for hospital expenses and surgical operations the 'blindness and paralysis' benefit or the 'permanent disability' indemnity, as it is called in some policies, which do not limit the forms of disability for which the indemnity is to be paid to blindness and paralysis, is the most common of the minor benefits promised in the health insurance policies sold by casualty companies. This benefit is a payment for permanent, total disability. Its nature can perhaps best be made clear by quoting a typical section which provides for it from a policy sold in Illinois by a well-known casualty company. This section reads in part as follows:

> " 'Special indemnity for blindness or paralysis. In the event that any disease for which indemnity is payable under the terms of this policy shall result, independently of other causes, in the irrecoverable loss of the entire sight of both eyes or in permanent paralysis whereby the insured shall lose the use of both hands or both feet, or of one hand and one foot, and on account of either of said conditions be permanently unable to engage in any labor or occupation, the company will pay said weekly sickness indemnity for the period of such blindness or paralysis, but not extending beyond one hundred and four weeks from the commencement of the illness or disease causing the blindness or paralysis.
>
> " 'No payment under the terms of this part * * * shall be due or payable until such permanent blindness or paralysis has continued for one year; further payments, if any, shall then be due and payable every sixty days but no payment whatever shall be due or payable except upon proof of the continuance of the blindness or paralysis during the period for which payment is claimed.'

"The above section further provides that the special indemnity for blindness or paralysis and the regular weekly benefit for sickness shall not be paid 'for any concurrent time' that is, that the payment

of the regular weekly benefit for sickness shall cease when the payment of the special indemnity begins.

"The policies which cover permanent and total disability from other causes as well as from blindness and paralysis vary somewhat in their terms. Most of these policies, however, cover permanent and total disability arising from the permanent and entire loss of the 'use of both hands or both feet, or one hand and one foot' as the result of sickness in addition to permanent and total disability arising from 'insurable paralysis.' A few of the industrial policies which have been submitted to the commission cover permanent total disability arising from any cause for which the ordinary (temporary) total disability benefit is payable in a clause which provides for the payment of a fraction (for example, one-fourth) of the regular monthly sum for as long a time as the total disability continues.

"In policies which provide for health insurance only, the amount to be paid under the 'blindness and paralysis' or the 'permanent disability' section is usually stated in terms of the maximum number of weeks or months for which the regular sickness benefit will be paid from the commencement of the illness including the period for which the regular indemnity is ordinarily payable, as in the policy quoted above. The maximum is fixed at one hundred four weeks in most commercial policies, but it is frequently fixed at one hundred weeks and sometimes at one hundred fifty weeks, one hundred fifty-six weeks (three years) or two hundred weeks.

"In combination health and accident policies the sum paid for permanent disability resulting from sickness is sometimes stated in the same terms as in the health policies and sometimes as a fraction of the 'principal sum,' which is the amount payable under the terms of an accident policy for death resulting from accidental bodily injuries. When stated in the latter way the amount is usually fixed at one-fourth, one-third, or one-half of the principal sum and made payable in full at the end of the first year of total permanent disability.

"*Benefits Promised in Accident Insurance Contracts.*

"The accident insurance policies sold by casualty companies resemble in many respects the health insurance contracts which have just been described. It will therefore be necessary in this section only to indicate the similarities and to describe briefly the points of contrast.

"It is the purpose of accident insurance to protect the insured, to quote a typical insuring clause, 'against loss resulting directly and independently of all other causes, from bodily injuries effected solely through external, violent and accidental means, suicide (sane or insane) not included.' The principal losses covered are loss of time, loss of sight, loss of limb and death.

"One of the most important respects in which the typical accident insurance policy differs from the typical health insurance policy is in the provision in the former for the payment of a sum called the 'principal sum' in the 'event of the death of the insured from accidental means.' It will be recalled that only five companies writing health insurance reported to the commission that they included provision for funeral benefits in health policies issued by them and that the maximum amount paid was, in each case, $100.

"The amount stipulated as the principal sum varies with the nature of the policy and, for a given class of risks, with the amount of the premium paid for it. Commercial accident policies commonly carry $5,000 or $7,500 as the principal sum for every $25 of weekly indemnity for disability resulting from accidental injury. Industrial policies differ widely in respect to the amount of the principal sum; one company, for example, writes industrial policies which provide for the payment in the event of accidental death of sums ranging from $100 to $1,200 according to the class of risk and the premium paid for the policy.

"The sums paid for loss of sight and loss of limb in the typical accident policy are fixed in terms of the principal sum. The schedule usually runs as follows:

| *"For loss of* | *Indemnity* |
|---|---|
| Both hands | The principal sum |
| Both feet | The principal sum |
| One hand and one foot | The principal sum |
| Entire sight of both eyes | The principal sum |
| Either hand or either foot, | One-half the principal sum |
| Either eye | One-third the principal sum |

"Some policies also provide specific indemnities in terms of the principal sum for the loss of either arm or either leg, the loss of either hand or foot and the sight of one eye, and the loss of the thumb and index finger of either hand. The indemnities for these losses have not been as well standardized as the indemnities for the losses indicated in the above table; in general they vary from two-thirds or three-fourths of the principal sum payable, in some policies, for the loss of an arm or leg to one-fifth or one-sixth which some policies promise for the loss of the thumb and index finger of either hand.

"Most policies provide that the dismemberment and loss of sight indemnities shall be paid only if the losses occur within ninety days of the date of the accident or, if the injuries continuously disable the insured from the accident to the date of the loss, within two hundred weeks. The reason for this time limitation has been stated as follows by a representativ eof the casualty companies.

" 'Experience has shown that if the loss is remote in period of time from the accident it will probably be contributed to by disease, or by causes other than accidental, and therefore not contemplated being covered by the policy, and it is to afford the company protection against liability for such complicated cases that the time within which the loss must be incurred is thus limited and qualified.'

"In addition to the specific indemnities for death, dismemberment and loss of sight, accident policies provide for the payment of the weekly or monthly benefit for total disability which continues from the date of the accident to the date of the occurrence of one of the losses mentioned.

"The weekly or monthly indemnity for total disability in accident policies is similar in amount (and

also in respect to the conditions under which it becomes payable) to the weekly or monthly payment for total disability in health policies. The former differs from the latter, however, in the time limit placed upon its payment, which ranges from two years in some policies to 'so long as the insured lives and suffers such total disability' in others, instead of being fixed at six or eight months as in most industrial health policies or fifty-two weeks as in most commercial health policies.

"Partial disability is defined in about the same terms in accident policies as in health policies. Payment of the indemnity for partial disability from accident is usually limited to one-half of the amount paid for total disability and to twenty-six or fifty-two weeks time.

"The weekly and monthly payments for total disability described above are paid for injuries which do not result in any of the specific losses indicated in the table and discussion on page 416. (Omitted.) The insured is usually given the option, however, of claiming the payment of certain fixed sums, called 'elective' or 'optional indemnities,' in lieu of the weekly or monthly indemnities in case he suffers certain injuries which are specified in the policy and which include loss of fingers or toes, dislocations and fractures. This option gives the insured the opportunity to secure an immediate settlement of his claim in full without waiting for the payment of the regular weekly or monthly indemnities—an opportunity which may prove desirable to an injured person hard pressed for cash.

"The hospital, surgical operation and medical treatment indemnities in accident policies are similar to those in health policies. The surgical operations schedule in the accident policy necessarily differs from that in the health policy because of the inclusion in the former of operations to reduce fractures and dislocations, amputations and the treatment of gun-shot wounds and the like, but where the same operation occurs in both schedules the amount allowed is usually the same for the same weekly or monthly indemnity. Accident policies which contain the sur-

gical operation indemnity feature commonly stipulate that any operation for which an allowance is paid must be performed within ninety days of the date of the accident, just as health policies make a similar stipulation with respect to the date of the commencement of the disabling sickness. The medical or surgical treatment indemnity of the accident insurance policy is the counterpart of the medical attendance or medical treatment indemnity of the health insurance policy, usually covering the cost of the treatment provided it does not exceed the amount of one week's benefit.

"Like some health policies a few accident policies have clauses which make specific provision for total disability resulting from paralysis. In these policies it is provided that if paralysis of a character to produce total disability occurs within ninety days of the date of accident or during a period of continuous total disability caused by accidental injuries a specified sum shall be paid in addition to the accrued weekly benefit and in lieu of all other indemnity The amount of the paralysis indemnity varies in different policies from one-third or one-half to one hundred per cent of the principal sum. A number of policies pay the same amount for loss of speech or hearing and a number pay it for insanity resulting from accidental injuries. The 'loss of sight' indemnity which corresponds to the 'blindness' in health policies, has already been described.

"Accident insurance was originally designed to cover the hazards of travel by railroad and steamboat. This original purpose is still shown in many policies by provisions which call for the payment of double indemnities for loss of life, limb, sight or time through accidents of travel.

"*Other Features of Health and Accident Policies.*

"In order to encourage the insured to renew his policy from year to year, or month to month, or, in the case of policies on which premiums are payable monthly, to pay his premiums annually or semi-annually in advance, many accident contracts and a few health contracts contain an 'accumulations' or 'annual increase' clause. In commercial accident

policies the clause commonly provides that the principal sum, and consequently the sum payable for death, loss of limb or loss of sight, shall be increased ten per cent of its original amount each year if successive premiums are paid annually in advance until the principal sum has been increased by fifty per cent after which there shall be no further increases. If premiums are paid semi-annually, or, in some policies, quarterly, the clause provides that the rate of increase shall be five instead of ten per cent with the same maximum aggregate accumulation of fifty per cent. In some of the industrial policies which contain an accumulations clause the clause provides that the principal sum shall be increased five per cent, up to a maximum aggregate of fifty per cent, 'for each full three months (for each month in some policies) immediately preceding the date of the accident that this policy shall have been maintained in continuous force.' In other industrial accident policies and in some commercial accident policies the accumulation feature is applied to the monthly or weekly benefit for disability; sometimes it is also applied to the indemnities specified in the schedule of minor injuries and the schedule of surgical operations. In industrial accident policies in which the accumulation feature is applied to the monthly indemnity the payment of the increased sum is usually a reward for the payment of premiums annually or semi-annually in advance. When the accumulations clause is included in a health policy it is applied to the weekly or monthly disability indemnity, rarely to other indemnities.

"The 'identification indemnity' clause is a feature of many health and accident policies. The clause commonly provides to quote the language of a typical combination health and accident policy, that 'if the insured, by reason of injury or illness, shall be physically unable to communicate with friends, the company upon receipt of a telegram or other message giving the number of the policy, will immediately transmit to his relatives or friends any information respecting him and will defray the expense necessary to put the insured in the care of friends, within the sum of one hundred dollars.'

"The term 'weekly' and 'monthly' as used in describing benefits for disability resulting from accidental injuries or illness have reference merely to the rate of indemnity and do not indicate the time at which, or the frequency with which the payment in question is to be made to the insured. The time or frequency of payment of the disability indemnity may be a matter of great importance to the insured. For that reason the law of Illinois requires that upon request of the insured payment shall be made at least once in every sixty days of half or more of the indemnity which has accrued since the last payment and that any balance remaining unpaid at the termination of the period for which the insurance company is liable shall be paid 'immediately upon receipt of due proof.' In accordance with the law most policies sold in Illinois provide for the payment of instalments of the disability benefit every thirty or sixty days or the nearest equivalent in weeks or months.

"The duration of the insurance contract is usually limited to one year in the case of commercial health and accident policies, and to one month in the case of industrial policies. The insurance company, however, usually reserves the right to cancel the policy at any time upon repayment to the insured of the unearned premium and it permits the insured to renew his policy upon its expiration, unless the company desires to discontinue the risk, by simply paying the premium for a new term. The purpose of the cancellation privilege is to protect the company against an adverse change in the risk upon which it had not counted in fixing its rates.

"In deciding as to the eligibility of an applicant for health or accident insurance casualty companies consider his sex, age, color or race, physical characteristics and condition, occupation, place of residence, other health or accident insurance carried by him and the relation between his income and the total amount of weekly or monthly indemnity which he could claim under all policies which he carries in case he were disabled by illness or accidental injuries.

"Some companies accept 'male risks' only; others accept 'female risks' under certain contracts drawn

exclusively for women; while still others insure men and women on the same terms. The companies which do not insure women and those which restrict women to special policies, claim that there are substantial grounds for discriminating against women, asserting that the recorded experience with female risks is too inadequate to serve as the basis for scientific rates, that it is more difficult to detect malingering and simulation in the case of women than in that of men, that women are more frequently disabled than men, or that there is a great moral hazard in the insurance of women against loss of time because disability in the case of women frequently does not influence the amount of income received by them and hence may be used as the basis for what is really an unjust claim for indemnity.

"The age limits within which applicants for health and accident insurance are accepted as policyholders vary for the two kinds of insurance and between different companies for the same kind of insurance. Most companies do not accept applicants for health insurance who are less than eighteen years of age nor more than sixty or sixty-five years of age at the nearest birthday; a few, however, accept applicants as young as sixteen or seventeen. The lower age limit for accident insurance is also usually eighteen but the upper limit is frequently as high as seventy years."

It is obvious that these policies are indefinite as to the time when the insurance takes effect and terminates. They are ambiguous as to the sicknesses and accidents causing the losses for which indemnities are provided and as to the character of the indemnities, and they are indefinite and ambiguous as to the amounts of insurance provided for the indemnities contemplated by the Standard Provisions Law.

It is ridiculous to contend that the Standard Provisions Law, designed to clarify, systematize, and regulate this business and to introduce order into chaos contemplates and authorizes the chaotic conditions described. It is folly to contend that a prospective policyholder under

existing conditions can pick out a policy and agree with the insurer on a contract which gives him the insurance he needs and desires.

Other than that the present policies contain the Standard Provisions and have been reformulated in some degree as to the details of settlements of claims, which is fully covered by the Standard Provisions, and that the one-fifth, one-tenth, and similar clauses have been largely but not entirely eliminated, the present policies are as ambiguous as the policies issued before the enactment of the Standard Provisions Law. They do not differentiate accident from sickness as causes of loss, and attempt to provide valued benefits for specifically described bodily losses and disabilities instead of the indemnities contemplated and authorized by the law. No attempt apparently has been made by the formulators to comply with the mandatory requirements of the law.

### Violations of Standard Provisions Law by Present Policy Forms

Policy forms have been issued in Wisconsin without having been filed with the department. They have been issued within thirty days after filing without having been approved. No company has filed a classification of risks and premium rates with each policy form filed. No insurer has filed a schedule of premium rates for the standard risk under the policy based on an amount of insurance. A schedule of premium rates, which the law requires shall be filed with each policy form, is worthless unless based on a definite amount of insurance, but policy forms essentially the same, with the same premiums, alike except in phraseology, and differing only as to the amount of insurance, have been the means used to obtain success in competition. When there was no competition, the greater protection was given only to friends of the solicitor and to those who had knowledge of the facts.

No insurer has filed a classification of risks based on the liability of individuals in the different occupations to

suffer a definite amount of loss, or the liability of the classes of occupations to suffer a definite percentage of the aggregate total loss. No classification of risks based on occupation has been filed by any insurer but the classifications of risks filed are invariably a conglomeration of occupations, exposures, and liability to meet with accidents, regardless in some cases of the consequent loss, only the number of accidents or cases of disability being considered, and in other cases emphasis being laid on the liability to meet with loss of life, dismemberment, or loss of sight.

Regardless of the positive regulation of the law, policies are issued which do not give "the entire money and other considerations" for a policy. This omission occurs mosts frequently in riders where the consideration is either entirely omitted (as it should be if the amount of insurance is not increased) or is inserted in general terms as "in consideration of the extra premium required therefor." Under the law the different classes of indemnity should be differentiated and distinguished and a schedule of premium rates and a classification of risks should be filed with the department for each kind of indemnity.

For the policies of full coverage, each insurer should file a schedule of premium rates and a classification of risks for loss of life by accident; a schedule of premium rates and a classification of risks for loss of time by accident; a schedule of premium rates and a classification of risks for loss of time from sickness; a schedule of premium rates and a classification of risks for loss other than that of time by accident, and a schedule of premium rates and a classification of risks for loss other than that of time from sickness.

For each policy of limited coverage, i. e., each policy having exceptions, like schedules of premium rates and classifications of risks should be filed.

The purpose of the law in this respect is disregarded by every insurer doing business in the state.

It may be argued that "loss other than that of time" includes "dismemberments," "loss of sight," "paralysis," and other specific bodily losses or disabilities, and that the present policy forms are an evolution and are evidence that the term "loss other than that of time" embraces them. The argument, however, disregards the fundamental fact that insurance means indemnity and that in order to indemnify for loss, the loss must be measurable. The fact also is disregarded that indemnity cannot be paid for pain, suffering, or inconvenience; that damages therefor are punitory in their nature and cannot be measured. The further fact is also disregarded that benefits paid as indemnity for loss of sight, dismemberments, etc., are a commutation of the benefits for loss of time and are measurable only as they cause a total or partial loss of time or earnings. The argument also gives no force to the purpose in the enactment of the law. The investigations of the commissioners of the settlements of claims of health and accident companies disclosed a situation as to the contracts which demanded radical regulation. The Standard Provisions Law was designed to remedy the conditions as to settlements disclosed by the examinations, which were primarily due to a failure to use a proper classification of indemnity.

*Duration of Policy*

The regulation of the law that the time when the insurance takes effect and terminates shall be stated in a portion of the policy preceding its execution by the insurer is disregarded in practically every policy issued. The law contemplates a policy of definite duration, which has a definite beginning and a definite termination. The manifest purpose of the law is to authorize and permit only policies for a definite period of duration. Policies are issued which give the duration of the policy as a single month, but provide for a continuation for periods of a month on the condition that the premium be paid and accepted.

Some of the policies being issued provide insurance for the term of a month or a year from a date fixed only by reference. In such cases there is not a literal compliance with the law. Most of the policies issued, however, provide for renewals indefinitely for terms of a month or year. In cases of renewals under such conditions, it is evident the time when the insurance takes effect and terminates is not stated *"in a portion of the policy preceding its execution by the insurer."* The requirements of the law might easily be met by giving the time the insurance takes effect and terminates for a year or five years, and providing for the payment of the premium in yearly or monthly instalments, subject to suspension by the failure of the insured to pay an instalment of the premium. The whole character of the contract as to this feature is changed by present practices in entire disregard of and in violation of the provisions of the law.

*Insurance of More Than One Person in Policies*

The prohibition of insurance of more than one person in a policy, designed to eliminate the insurance of the beneficiary and to give every person insured a contract of real insurance, is evaded, dodged, foiled, and eluded by the issue without additional cost of a separate policy, called at first, a beneficiary policy, having a coverage so limited that it gives no real protection, and which violates the purpose and even the letter of the law in other respects than the prohibition against the insurance of more than one person in a policy. Under an opinion of the Attorney General the issue of this kind of policy was held violative of the law, but practically the same policy is being constantly submitted for approval.

*Description of Policy on Face and Filing Back*

In practically all the policies issued there is a violation of the purpose, if not of the letter of the provision of the law, requiring a brief description of the policy to be printed on the face and filing back. In the law payment

of certain kinds of indemnities is contemplated and provided for and the policies construed under the law can provide these indemnities only. In the descriptions of the policies, indemnities are provided for losses not mentioned in the law or the Standard Provisions, and words of limitation and restriction are included in the descriptions of which the application is ambiguous. It is impossible to determine from the descriptions whether the limitations and restrictions are designed to apply to the cause of loss, the loss itself, or the amount of insurance provided by the contracts.

*Exceptions from Policies*

The provisions of the law requiring that the exceptions shall be printed with the same prominence as the benefits to which they apply is not observed in the policy forms now being issued. There seems to be no appreciation on the part of the formulators of what really is an exception. Provisions are inserted in the policies which relieve the insurer from liability if any accident or a disease does not take a course predetermined by the insurer. These provisions, such as confinement to the house, attendance of a physician, immediate disability from accident, etc., are defended as designed to protect the insurer against fraudulent claims, but are construed as determinative of liability and the amount of liability when claims are adjusted. Provisions are placed in the policies relieving the insurer from liability if there be a change of occupation, or if the insured is exposed to a hazard of an occupation not characteristic of the occupation stated in the application. This is a matter of the classification of risks and premium rates and not one of exceptions, and has no place in the policy.

There are provisions in the policies which relieve the insurer from the greater part of the liability if the loss be due to a particular accident or disease. In these provisions, an exception is confused with and not differen-

tiated from disability or bodily loss, from occupation, and from the amount of insurance. Not only are such provisions treated as exceptions, but they, as well as real exceptions of accidents and diseases, are not printed within or in proximity to the provisions for indemnity, but they are placed at the end of the policies as far as possible from the provisions for indemnities. Either by ignorance or design in the formulators of the policies, the policyholder is mislead and deceived as to his legal rights and in settlement of his claim is induced to accept less than his due.

*Provisions for Reduction of Amount of Insurance by Reason of Circumstances under which Loss is Incurred*

In formulating provisions under that portion of the law which provides that "any portion of such policy which purports by reason of the circumstances under which a loss is incurred to reduce any indemnity promised therein to an amount less than that provided for the same loss occurring under ordinary circumstances shall be printed in bold face type and with greater prominence than any other portion of the text of the policy," this provision is not construed in connection with the other provisions of the law and a meaning given to it in harmony therewith as enabling the insurance of sub-standard risks and as a positive regulation of other authorized provisions which reduce the indemnity stated in the policy, but it is construed as independent of and superior to and modifying the other parts of the law and as authorizing provisions for valued benefits for specific disabilities or bodily losses, regardless of the cause, and as authorizing insurance against specific accidents and diseases. The term "circumstances" is construed as though it were a general term embracing "accident," "sickness" or "disease," "loss," "loss of life," "loss of time," "loss other than that of time," "specific bodily losses," "disability," "amount of insurance," "amount of indemnity," "occupation," "sex," "age," etc.

### Construction of Standard Provisions

The formulators of present policy forms and the insurers have given to the consideration of subsection (3) of the Standard Provisions Law the same superficial examination as has been given to the other mandatory provisions of the law. Subsection (3) provides:

> "Every such policy so issued shall contain certain standard provisions, which shall be in the words and in the order hereinafter set forth and be preceded in every policy by the caption "Standard Provisions."

Whenever the question of the effect of this subsection is raised with the insurers, the general contention is that the insurer has met in full the requirements of the law when the Standard Provisions have been printed in the policies. When claims are being adjusted the contention is made that the Standard Provisions are law as to the claimants and are restrictive and limiting upon a claimant's rights. Both contentions are false and unwarranted. As between a claimant and the insurer the Standard Provisions are no different from the other provisions of a policy. They are restrictive as law on a claimant only in so far as they fix the time within which notice of claim is to be made, the time within which proof is to be made, the effect of a failure to comply with these restrictions, and as there is a recognition of the duty of a claimant to submit to a medical examination in behalf of the insurer. The purpose of the law was to restrict and regulate the exercise of powers by the insurer in the matter of claim settlements. As between the state and the insurer, the state prescribes the procedure to be followed and such procedure is law for the insurer. The contentions of the insurers allow no force to subsection (9) of the law and disregard subsection (5), providing as follows:

> "*Contradictory provisions prohibited.* (5) No such policy shall be so issued or delivered if it contains any provision contradictory, in whole or in part, of any of the provisions hereinbefore in this act desig-

nated as 'Standard Provisions' or as 'Optional Standard Provisions'; nor shall any indorsements or attached papers vary, alter, extend, be used as a substitute for or in any way conflict with any of the said 'Standard Provisions' or the said 'Optional Standard Provisions'; nor shall such policy be so issued or delivered if it contains any provision purporting to make any portion of the charter, constitution or by-laws of the insurer a part of the policy unless such portion of the charter, constitution or by-laws shall be set forth in the policy, but this prohibition shall not be deemed to apply to any statement of rates or classification of risks filed with the commissioner of insurance in accordance with the provisions of this act."

With the exception of Standard Provisions No. 2 (Changes in Contract), No. 3 (Reinstatement after Lapse), and No. 12 (Cancellation at the Instance of the Insured) and Optional Standard Provision No. 16 (Cancellation by Insurer,) and No. 20 (Age Limits), all of the Standard Provisions and the Optional Standard Provisions deal primarily with the proof and adjustment of claims. The scope of this report does not include the consideration of the duty and the obligations of a policyholder or claimant to the insurer, and the Standard Provisions will be considered in their order only as they affect the forms of policies to be issued under the law and their violation of the law by present policy forms. The violations of the Standard Provisions in the settlement of claims is another question.

Before entering upon such a consideration, it is pertinent and necessary to quote subsection (4) of the Standard Provisions Law, which reads as follows:

"*Conditions prohibited.* (4) No such policy shall be so issued or delivered which contains any provision (1) relative to cancellation at the instance of the insurer; or, (2) limiting the amount of indemnity to a sum less than the amount stated in the policy and for which the premium has been paid; or, (3) pro-

viding for the deduction of any premium from the amount paid in settlement of claim; or, (4) relative to other insurance by the same insurer; or, (5) relative to the age limits of the policy; unless such provisions which are hereby designated as optional standard provisions, shall be in the words and in the order in which they are hereinafter set forth, but the insurer may at its option omit from the policy any such optional standard provision."

### Disregard of Law and of the Standard Provisions in Present Policies

The only basis for a classification of risks recognized in the law or the Standard Provisions which may reduce the amount of liability of the insurer is occupation. One form of Standard Provision No. 1 recognizes the fact that a classification of risks determines the differences in premiums for different risks. The other form of this provision provides that there shall be no reduction of the indemnity because of a classification of risks. Interpreting both forms of this provision together, there is a recognition of the fact that the amount of indemnity is directly related to the amount of the premium. In other words, a classification of risks fixes the premiums and the amounts of indemnities. Despite the fact that occupation is the only basis for a classification of risks recognized in the law many of the policy forms now being issued have provisions for a reduction of indemnity by reason of sex or age. Many insurers provide in the schedule of premium rates for higher premiums by reason of sex or age. Such provisions and such a schedule of premium rates made part of a policy are manifestly contradictory in part of Standard Provision No. 1, and, hence, violative of subsection (5) of the Standard Provisions Law. An insurer may be acting within its rights in refusing to issue a certain form of policy to a sex or to persons below or above certain ages, but such a regulation must be a regulation within the insurer's conduct of its

business and has no place in a policy formulated under the law.

In the great majority of the policy forms issued in this state after the enactment of the Standard Provisions Law, Standard Provision No. 1, providing for a reduction of the indemnity on account of change of occupation, is printed in the same size and form of type as the other provisions of the policy, in violation of the provision to subdivision (6) of subsection (2) of section 1960, providing "any portion of a policy which purports by reason of the circumstances under which a loss is incurred to reduce any indemnity promised therein to an amount less than that provided for the same loss occurring under ordinary circumstances shall be printed in bold face type and with greater prominence than any other portion of the text of the policy."

There is general ignorance among insurers of the meaning of the clauses occurring in the two forms of Standard Provision No. 1 "by reason of his doing any act or thing pertaining to any occupation so classified." This ignorance manifests itself in the adjustment of claims. For instance a stationary engineer, working nights, whose duty it was to pull certain electric light switches, and whose death was due to accident, is reclassified as electrical switchboard attendant, although the death was not caused thereby and this duty was known to the insurer when the policy was issued. A real estate broker injured while experimenting in blowing out roots with dynamite is classified as a handler or user of dynamite. The classifications of risks filed with the department were defective in both cases, being based on occupation, exposure, age, sex, and other things. There was no change of occupation in either case. The accident or exposure in each case was incidental to every occupation. The reduction of the indemnity in the first case could only be warranted if the insured were insured as an electrical switchboard attendant not pulling switches, if the insurer had subclassified

the occupation of electrical switchboard attendant into "not pulling switches" and "pulling switches," and if the death was due to the act of pulling the switches. In the other case the reclassification would be warranted only if the policyholder had been insured under the occupation of "land clearer not using dynamite," if the insurer had subclassified the occupation of land clearer into those "not using dynamite" and those "using dynamite," and if the injury was the result of using dynamite in his occupation. "Any act or thing" in Standard Provision No. 1 simply recognizes the right of and authorizes the insurer to make subclasses of occupations in the classification of risks. Construing Standard Provision No. 1 in connection with the other provisions of the law, an insurer is obliged to file with the department a classification of risks, based on occupation and subclasses of occupation, and a schedule of premium rates for the standard risk and for each class for each kind of indemnity provided by a policy.

Standard Provision No. 2 means nothing under the policy forms now being issued. It is designed to protect the insurer against claims in excess of indemnity and claims for indemnity for losses not included in the contract. Literally construed, the present policy forms do not purport to provide indemnity but only specific benefits for specifically described bodily losses or disabilities. Present policy forms also do not differentiate the losses insured against and do not differentiate accident from sickness. Construing present policy forms under the law, the question of a benefit being in excess of indemnity cannot be raised, for the insurers have estopped themselves from raising the question by the provisions of their policies. Nor can the question of the kind of loss included in a contract be raised, for the insurers have not observed the classification of indemnity made in the law, into indemnity for loss of life by accident, indemnity for loss of time by accident, indemnity for loss of time from sick-

ness, indemnity for loss other than that of time by accident, and indemnity for loss other than that of time by sickness. The result is that present policy forms literally construed nullify Standard Provision No. 2.

Most of the companies pay no attention whatsoever to Standard Provision No. 3. The policy forms now used contain provisions which clearly show that the making of a contract and the renewal of a contract are not distinguished from the reinstatement of a contract. The renewal of a contract is the making of a new contract on the same terms and conditions as a previous one. The law prohibits the making of a new contract which does not comply with the law. A contract which has terminated cannot be reinstated. The law does not contemplate renewals. In fact, a contract cannot be renewed under the law, for under the law the time when the insurance takes effect and terminates must be stated in a portion of the policy preceding its execution by the insurer. Practically all of the contracts being issued contain provisions for renewal. Construing such contracts under subsection (9) of the Standard Provisions Law they must be held to provide insurance from the time they take effect to the death of the insured or to the attainment of the maximum age limit stated in the policy, subject to lapse by the failure of the insured to pay an instalment of the premium for any period and to reinstatement by payment of the instalments of the premium in full. Even with such a construction there are violations of the law and disregard of Standard Provision No. 3.

Policies lapse for non-payment of the premium and are reinstated after the lapse of months without the premium for the period during which the policy was lapsed being collected. Not only are policies which had been issued under the Standard Provisions Law and which have lapsed reinstated without the premium being collected, but policies which were issued before the enactment of the Standard Provisions Law, which have lapsed or have

been canceled by the insurer and which contain no provision for reinstatement after lapse, have been reinstated. Not only is the law violated by the insurer under such conditions but the insurer asks the department to approve the violation of the law.

Standard Provision No. 5 is also disregarded. The purpose of this provision is to allow a claimant to give notice to the agent of the company with whom he has his dealings. Some of the insurers practically nullify this purpose by providing that the secretary, or claim adjuster, at the home office of the company shall be the person to whom the notice is to be given.

Standard Provision No. 7 relating to filing proof of loss is nullified by the provisions of present policies. Despite the positive prohibition of the law that no Standard Provisions shall be changed or modified, many of the policy forms contain a provision requiring a claimant to furnish proof of loss every thirty days, and further providing that in the event that such proof is not furnished a claimant loses his right to indemnity.

Under Standard Provision No. 6 the insurer is required to furnish forms to a claimant on which to make proof of his loss. Under Standard Provision No. 7 the claimant is required to furnish proof of loss within ninety days after the occurence of the loss or the termination of the period of disability, and under Standard Provision No. 10, upon request of the claimant, the insurer is required to pay not less than one-half of the accrued indemnity at the expiration of not to exceed each sixty days. The requirement that a claimant shall furnish proof every thirty days manifestly modifies the rights to make proof within ninety days after the occurrence of a loss or the termination of the period of disability, and to require a partial settlement at least every sixty days, which the claimant has under Standard Provision No. 7 and 10, and also is a shifting of the burden of investigation of

the validity of a claim imposed on the insurer by Standard Provision No. 8; all contrary to subsection (5) of the law.

Although Standard Provision No. 9 is printed in all of the policy forms being used, this provision is ineffective under present policy forms. In these forms, the distinction between loss of life, loss of time, and loss other than that of time, is not made as is contemplated by the law. Construing the policy forms literally, the result is that it is impossible to make a claim for loss other than that of time and the final result is that Standard Provision No. 9 is not effective.

Although Standard Provision No. 10 is printed in practically all of the policy forms now being issued in this state, like Standard Provision No. 9, it is practically never followed in the settlement of claims. The reason it is not applied is the same as that for the non-application of Standard Provision No. 9, namely, that the present policy forms do not differentiate the elements of these contracts as contemplated by the law. In this connection one fact stands out conspicuously. Although the policy forms now being issued must be construed to provide indemnity for loss of time from sickness for from six months to the death of the insured, claims for the maximum indemnity as shown by the amount of insurance provided are never paid. But in the event of a claimant becoming afflicted with a chronic illness or suffering a bodily loss, which will permanently partially disable him, the insurer will cancel the policy and thus deprive the insured of practically all the insurance provided by the policy.

Many of the policies now being issued have provisions for the payment of indemnities otherwise than as provided by Standard Provision No. 11. For instance, accrued indemnities for loss of time are made payable to the beneficiary in the event of death of the insured.

The purpose of Standard Provision No. 12 is to give the insurer the benefit of the larger indemnity or a lower

premium in case of a change of occupation to one less hazardous than that stated in the application. The spirit of this provision is disregarded in formulating the policies and operating the business. It is practically impossible for a policyholder to take advantage of this provision. He knows nothing of the classification of risks made by the insurer and if he were in possession of a classification of risks, it would still be impossible for him to avail himself of this provision because no classification of risks has been filed by an insurer which is a classification of risks based on occupation. The classifications of risks which have been filed with the Department are a conglomeration of occupation, exposure, age, sex, and place of residence, with no logical basis for classifying, and because so constructed nullify Standard Provision No. 12 in the operation of the business.

Standard Provision No. 13 negatives the right of a beneficiary to any control of a policy. But in case of death from accident, the right of the beneficiary to the death benefit becomes fixed. All of the technicalities and limitations in the policy are made use of by the insurer to defeat the claim of the beneficiary. If disability was not immediate and total at the time of the accident, often the claim is rejected. Claims are rejected because an accident has not taken the course pre-determined by the insurer. For instance, if an accident results in septicemia or tetanus, the claim is made that the insurer is not liable because the insurer died from disease. Injustice is done the beneficiary in these cases only because the policy forms are wilfully or ignorantly ambiguous, and not in harmony with the theory of the law.

In Wisconsin the time limit for the commencement of an action upon an insurance claim is six years. Standard Provision No. 14 is in conflict with the general insurance law on this subject. The Standard Provisions as between the insurer and the insured are not law. The law requires that the Standard Provisions shall be placed in a policy

and then become part of contract. When placed in a policy, they are subject to construction just as any other provision of a policy. It will be readily seen that a claimant may under Standard Provision No. 14 be deprived of rights which he has under the general law.

Standard Provision No. 15 is designed to preserve certain rights to the insured or claimant as to the time for giving notice of claim or furnishing proof of loss. Manifestly it affords no protection to a claimant unless he be versed in the law. The insurer is able to and does take advantage of a claimant because of provisions in the policy in spite of Standard Provision No. 15.

Subsection (4) of section 1960 is disregarded in some respects in most of the policies which are being issued. Subdivision (1) prohibits any provision in the policy "relative to cancellation at the instance of the insurer" unless it be in the form of Optional Standard Provision No. 16. Optional Standard Provision No. 16 is omitted from some of the policies and the policy contains a provision that if the insured meets with a specifically described bodily loss or disability, the insurance terminates. In some of the policies, the provision is that the payment of a specific benefit shall terminate the insurance. There are in some of the policies provisions for termination of the insurance in the event of a failure to pay a so-called renewal premium, and the further provision that the acceptance of a renewal premium shall be optional with the insurer. All of these provisions are obviously in conflict with the subdivision of subsection (4) above quoted.

Subdivision (2) of subsection (4) of section 1960 prohibits the insertion in a policy issued under the law of any provision "limiting the amount of indemnity to a sum less than the amount stated in the policy and for which the premium has been paid," unless it would be in the form of Optional Standard Provision No. 17. Optional Standard Provision No. 17 is omitted probably from a majority of the policy forms, but the policy forms contain provi-

sions which literally construed effect a reduction in the indemnity provided by the contracts.

This regulation of the law is violated in some respect in practically every contract issued. The contracts are formulated and are construed in the settlement of claims to relieve the insurer from liability if disability is not immediate or within a limited period after an accident. The indemnities are decreased or entirely eliminated unless there be confinement to the house and the attendance of a legally qualified physician. Indemnities are reduced under an arbitrary classification of risks which is based on liability to meet with fatal or permanently disabling disabilities regardless of the liability to meet with loss of time.

If a risk becomes a subnormal risk as to the amount of insurance which would indemnify because of a bodily loss or by reason of a chronic or recurrent disease, the policy is canceled by refusal to renew at the time of the next premium payment, and there is frequently a provision in the policy, contrary to the law, providing for an automatic cancellation, when a risk becomes subnormal, as to the amount of loss the insured may suffer.

The policies provide specific benefits for specifically described bodily losses or disabilities. For instance, a benefit is provided for the loss of a hand above the wrist, and a specific benefit is provided for disability which is not total but which prevents the insured from performing "duties substantially essential" to his occupation. These policy provisions might be unobjectionable if the indemnity could be and were calculated for all possible cases of loss or disability of the insured. This is obviously impossible. In the settlement of claims the amount of the liability of the insurer, is considered as limited to the amount provided for the specifically described cases of disability set out in the policy, regardless of the cause of loss and the amount of loss suffered by the insured. The insured is thus deprived, in violation

of the law, of a large part of the insurance which the law contemplates a policy shall provide.

Subdivision (3), subsection (4), section 1960, prohibits any provision in such a policy providing for the deduction of any premium from the amount paid in settlement of a claim unless it be in the form of Optional Standard Provision No. 18. Despite this provision, so-called renewal premiums, whether due or not, which in fact under the law are only the premiums for definite periods or terms which are parts of the term of the policy, are deducted from the amount of claims. The fact that the policy forms do not provide definite terms of insurance, as contemplated by the law, makes the character of the so-called renewal premium ambiguous, and makes it difficult to apply this provision of the law. If the so-called renewal is in fact a renewal, then a new contract is made and there is no right to deduct the premium from the amount of a claim, for no premium is due. If the so-called renewal premiums are in fact simply instalments of the premium, there is a misnomer in the policy which misleads and deceives the insured and renders the contracts ambiguous, and by a violation of the law renders this subdivision ineffective.

Subdivision (4), subsection (4), section 1960, prohibits any provision "relative to other insurance by the same insurer" unless it be in the form of Optional Standard Provision No. 19. The enabling paragraph to the different forms of Optional Standard Provision No. 19 provides that the insurer shall insert in the blank spaces "such upward limits of indemnity as are specified by the insurer's classification of risks, filed as required by this act." It is safe to say that this portion of the law is never observed by the insurers in the use of this Optional Standard Provision. Instead of inserting in the blank spaces "such upward limits of indemnity as are specified by the insurer's classification of risks, filed as required by this act," the almost invariable practice is to insert the

amounts provided by the policy, thereby effecting a cancellation of all other policies issued by the insurer to the individual insured. The blank space to be filled in with the aggregate indemnity for loss other than that of time is filled with the amount payable under the policy for single, double, or triple indemnity for loss of life, regardless of the limit of indemnity which might be provided in the classification of risks for indemnity for loss of time in the occupation of the insured, and not differentiating "loss of life" from "loss other than that of time."

Subdivision (5), subsection (4), section 1960, prohibits any provision in a policy, (5) "relative to the age limits of the policy" unless it be in the form of Optional Standard Provision No. 20. Regardless of this provision of the law and of subsection (5) of the law prohibiting any provision in a policy, "contradictory in whole or in part" of the Standard or Optional Standard Provisions, many of the policies being issued contain provisions providing a change of rate of premiums after a certain age, for the cancellation of the health insurance at a certain age and the cancellation of the entire policy at a certain age. The policies which contain the provisions for termination of the insurance at certain ages usually do not have Optional Standard Provision No. 20.

Perhaps no policy being issued at present contains all the violations of the Standard Provisions Law and of the Standard Provisions which have been mentioned. Every policy, however, which is being issued does violate the law in some respect. Moreover the tendency in the business is not toward conformity with the law in the formulation of policies, but, on the contrary, the disregard of the law and the Standard and Optional Standard Provisions is more marked in the new policy forms which are being submitted.

It may be well to note in a general way the salient features of the policy forms submitted to the department since the enactment of the Standard Provisions Law

wherein the violations of the regulations of the law are emphasized. As already stated the phraseology of the contracts was not changed except as required by the Standard Provisions regulating the settlement of claims. The number of policy forms was not decreased and standardized as contemplated by the law.

Shortly after the law became effective the number of limited accident policies was multiplied, literally hundreds of such forms being filed with the department. The limited health policy modeled on the theory of the limited accident policy came into prominence about the middle of 1915. The theory of the law is that an accident policy embraces all accidents and a health policy embraces all diseases except those expressly excepted. The theory of the limited policy is that it covers only such accidents or diseases as are expressly mentioned.

These limited policies failed to meet with popular favor although pushed hard by certain of the insurers. They ran their course in the two or three years following the enactment of the law and failed of success because they did not meet and satisfy the public need and demand.

The aggressive and superficial students of insurance among the insurers next took up the policy form commonly known as the "Pacific Disability Policy," wherein all accidents and diseases were covered, but the term "disability" was emphasized in contradistinction from "loss," and as so distinguished was restricted by various phrases descriptive of specific disabilities; "immediate, continuous and total disability," "confines the insured within the house," "requires the attendance of a physician," etc., reducing the amount of insurance. This form and its modification failed to arouse popular enthusiasm in the two or three years when it was pushed.

In 1919, the so-called "non-cancellable policy" in several variations was issued by one of the insurers and quickly copied by others. This form now engages the activities of those insurers and agents who are not con-

cerned with the real problems of health and accident insurance as an instrumentability for rendering service to the public. The salient feature of this policy form in violation of the law is the exclusion of indemnity for loss of time for one, two or three months and the attempted elimination of indemnity for partial loss of time contrary to subdivision (2) of subsection (4), section 1960, prohibiting any provision "limiting the amount of indemnity to a sum less than the amount stated in the policy."

It is perhaps proper at this point to take upon myself the role of a prophet. The idea is in process of formation that the moral hazard in the health and accident business may be eliminated by combining this business with life insurance, charging higher premiums and incorporating the investment element of life insurance into health and accident policies. I predict that within six months policies embodying this idea will be submitted to the department. Such forms will be accumulative evidence that many, perhaps most, of the health and accident insurers are not informed in the fundamentals of insurance and do not differentiate the various kinds of insurance from one another. Premature death is the cause of loss in life insurance; personal accident and disease are the causes of loss in health and accident insurance. A level premium, necessarily involving an investment, is an essential of practical life insurance; during the earning period, in health and accident insurance, the hazard of loss does not increase with age. In life insurance the contingency of death is certain to occur with a consequent total loss; in health and accident insurance, except in cases of loss of life by accident, the loss of time or earnings is not liable to occur and when it does occur is only temporary and partial, and there is the additional loss from expenses for care and treatment of the person. In life insurance the amount of insurance and the amount of indemnity is the same and is a fixed amount; in health

and accident insurance, except in case of accidental death, the amount of insurance varies from nothing to the duration of life, and the amount of indemnity differs with every settlement. In life insurance there is always a beneficiary other than the insured; health and accident insurance contemplates that the insured shall himself be the beneficiary. The disregard of these differences must inevitably produce policies which are out of harmony with the theory of health and accident insurance.

## PART II

### Policy Form Submitted for Criticisms and Suggestions

For the proper consideration of all the criticisms and suggestions which have been returned on the health and accident policy form submitted with the letter of May 21, it is necessary to collate and classify them.

The policy form was sent originally to all of the state departments and to all of the companies and associations doing a health and accident business in Wisconsin. It was also sent to some friends in the business. Later it was sent to the members of the Health and Accident Underwriters' Conference, not doing business in Wisconsin, and in answer to some requests.

In a general way, the answers of the departments considered the policy form under the Standard Provisions Law as calculated to put the business on a better basis, while the insurers disregarded the law and laid stress on present, temporary conditions in the business, without considering the adequacy and efficacy of present practices in meeting present needs and the future growth and development of the business.

### Departmental Replies

In so far as there were expressions of opinion from the departments, the approval of the policy form submitted was unanimous. Several of the departments suggested that the form be submitted to the Commissioners' Convention for adoption, with some changes in phraseology, as the standard form. One of the departments went outside of the question of the policy form and suggested that the right of cancellation be taken from the insurers. Some of the departments stated that they were greatly interested in the matter and promised further

study of the subject. One department suggested that the greatest definiteness in the matter of benefits was desirable, but approved of the form as likely to bring decided improvement in the business. This was the nearest to a criticism made by any department.

**Committee of the Executive Committee of Health and Accident Underwriters' Conference**

As already stated the policy form was originally sent to some friends in the business. Among these was the President of the Health and Accident Underwriters' Conference. No reply was received from him. Shortly after sending the policy form and the accompanying letter to the president of the conference, letters were received from several companies not doing business in Wisconsin asking for copies of the policy form, and stating that they had received a letter from the president of the conference advising them not to reply individually to this department but to leave the matter to a committee of the executive committee, which would report to the executive committee at the coming meeting of the conference. The president of the conference was advised that the department had been informed of his letter, and the writer offered to give the committee the use of the material collected and every assistance in the preparation of their report. The president replied that the matter had gone out of his control into the hands of the executive committee and that he assumes the committee to be appointed would make a thorough investigation of the matter. Upon request the chairman of the executive committee gave the names of the committee. An offer to the members of the committee to meet with them and work out a report developed the fact that the chairman and one member of the committee were away on vacations and would not return until too late to consider the matter before the meeting of the conference.

The third member of the committee replied promptly, stating that he believed in standard forms of policies

and, evidently expecting that the committee would not meet and do any real work on the matter, asking that he be furnished with the reasons for the various provisions in the form submitted. In reply he was advised that the form could not be finally settled until the suggestions and criticisms asked for had been considered. He was promised a copy of the report when completed.

No report was made by the committee to the executive committee of the conference at the meeting in the first week of September, 1919, and the matter was not considered by the executive committee or the conference.

### Replies of Insurers

The replies received from members of the Health and Accident Underwriters' Conference are evidence that many members of the conference favor the *standardization of health and accident policy forms.* A considerable number of members of the conference and a number of insurers not in the conference approved the policy form submitted and expressed the hope that the time might come when they would issue only such a policy, but in view of the opposition of so many of the insurers, and especially the strong and general opposition of the larger companies, they expressed the fear that it could not be issued by them at present. The need of standardization of policy forms and the elimination of frills therefrom were acknowledged as prerequisite to the growth and development of the business, but these insurers were apprehensive that they did not have the resources to take the initiative with a reasonable expectation of success.

The majority of the insurers who have answered the letter of May 21, disapprove the standardization of policy forms on the various grounds which will hereafter be considered. An examination of the criticisms submitted shows them to be inconsistent with one another. They are fragmentary and disconnected, and manifestly are not based on a comprehensive conception of the business and

its elements and on an informed construction of the law. They are, in fact, not criticisms of the policy form but are a defense of present policy forms and company practices.

The opening sentence of the letter of May 21, states that the policy form enclosed "is designed to provide all of the insurance authorized by the Standard Provisions Law." If the purpose to formulate a policy form providing all the insurance authorized by the law was realized, the criticisms are neither more nor less than criticisms of the law itself. Whether or not the criticisms of the law are valid is impossible to say, for the reason that insurance under the law has been tried out in only the few cases which have come before the courts. The great mass of present policies have been formulated and adjustments have been made in almost entire disregard of the law. In the cases which have been before the courts the policies have been construed and the law has been interpreted in harmony with the construction and interpretation used in formulating the policy submitted.

The first impulse, therefore, was to answer the criticisms generally with the observation that it was apparent that the writers had disregarded the Standard Provisions Law and, therefore, were not writing on the question under consideration. The adoption of standard forms, however, would materially change present practices and the criticisms should therefore be discussed.

*Evolution.* It is asserted that present policy forms are the outgrowth of a process of evolution, that this process should be allowed to continue under the control of the insurers, and that the adoption of standard forms of policies would stop this evolutionary process and the consequent development of the business. The truth is that the present forms of health and accident policies are largely survivals of forms which were inapplicable to the purchasers, and which were sold under such conditions as to induce prospective policyholders to believe they would

get such health and accident policies as they needed and desired, especially as to amount, while the intent was to provide much less; they also embody the attempts to avoid the effect of court decisions construing the policies to provide the insurance policyholders believed they were getting and were entitled to; and, finally they are the result of the attempts on the part of the insurers to evade the operation of the Standard Provisions Law. Present policies are not an evolution but are essentially a conglomeration of deceptions and evasions of duty.

It is alleged that the standard form of policy submitted is revolutionary and would engender a great amount of controversy and require an endless line of court decisions for construction and interpretation.

The first statement in the letter accompanying the policy form submitted is that it is designed to "provide all of the insurance authorized by the Standard Provisions Law." The Standard Provisions Law is essentially a codification of the law and court decisions existing at the time of its enactment.

The policy form submitted, therefore, is not revolutionary except in the sense that it would tend to end deception and inequity in this most important branch of insurance. It is truly an evolution in that it embodies the effect of court decisions eliminating the inequitable limitations and restrictions which have been common in these policy forms. There would, therefore, be little need for construction and interpretation.

Moreover, the investigation of settlements in 1911 disclosed that the ordinary small claim when allowed was allowed by the claim adjusters for the insurers on the whims of the adjusters in disregard of technical clauses and provisions of the contracts and that any allowance was treated as a gift or gratuity; the size of the gratuity was a measure of the generosity of the insurers; and claims were rejected by a rigid application of technical clauses and provisions and not on grounds of equity or

law. It may fairly be said that the primary purpose in the enactment of the Standard Provisions Law was the establishment of such rules for the adjustment of claims, that no recourse to the courts would be necessary for legal construction, but such recourse would be limited to cases where there was dispute as to the facts.

*Insuring Clause Incomplete.* The insuring clause of the policy form submitted was criticised as incomplete in that the contingencies of accident and sickness were not distinguished and differentiated and defined therein. The only objection to adding to the clause the definition of the insurance regulated by the law in subsection (1) of the Standard Provisions Law, and included in the policy, namely, "against loss or damage from the sickness or the bodily injury or death of the insured by accident" is that there would be a repetition. The losses against which insurance is provided and the amount of insurance are thereafter specifically described in the appropriate clauses. Nothing could be gained by repetition. The criticism of a want of differentiation of "accident" from "sickness" might have had some force twenty years ago, but the distinction between and the differentiation of "accident" from "disease" as causes of bodily disability had been made by the courts when the Standard Provisions Law was enacted and were of course incorporated and embodied in the law.

*Special Indemnities Omitted.* It is claimed that the policy form submitted is objectionable and is not an improvement on present policy forms because the ordinary provisions for the payment of specific benefits for dismemberments and loss of sight are omitted. It is asserted that insurance against such losses are just as legitimate as insurance against loss of time. This criticism raises the question of the force or effect under the Standard Provisions Law of such provisions in the forms now being issued.

Vice-President Page of the Travelers said in a lecture before the Insurance Institute at Hartford:

> "Accident insurance was designed primarily to compensate the insured for loss of business time. It was never intended as a bonus or to put a premium on injury. The specific amounts paid immediately for accidental loss of limbs or eye-sight, the optional benefits for certain fractures and dislocations, are a commutation of the amount which would otherwise be paid under the weekly indemnity feature."

The law does not authorize premiums for insurance against such losses, nor does the Standard Provisions Law like the Workmen's Compensation Act fix the percentages or portions which such losses shall bear to a total loss or the amount of insurance provided by a policy. Under subsection (9) of the Standard Provisions Law a policy which is issued in violation of the act, i. e. is not in compliance with the act, is nevertheless to be construed under the act.

If policies with provisions for specific benefits be construed under the law, they must be held to provide the indemnities authorized by the law. If such policies be construed to provide indemnity for loss of time the provisions for specific benefits must be held to be in the nature of offers on the part of the insurer to make settlements of claims for such loss of time under the conditions and limitations set out in these provisions, and the amounts offered must be held to be commutations of the indemnities for loss of time which the claimant would receive. The acceptance of such an offer is of course optional with a claimant. Upon acceptance of an offer, the benefit becomes a valued one and the insurer is estopped from raising the question of whether or not the benefit is in excess of indemnity. The only question that can be raised is whether or not the claimant has met the conditions of the offer. Anderson v. Aetna Life Ins. Co., 28 L. R. A. (N. S.) 730, and note; Kangas v. Standard Accident Ins. Co., 1918B L. R. A. 504, and annotation.

*Disability Less than Total.* The policy form submitted is criticised because it contains no provision for the payment of benefits for loss of time where the loss of time is not total because disability is not total, but is intermittent or partial, or the claimant does not require medical or surgical treatment, or is not confined to the house. The primary function of insurance is to provide protection against loss from the contingencies included in the contract. In the clauses of the form submitted providing indemnity for loss of time, a recovery is limited to the loss established and is also limited to a definite sum per month or week and to a definite number of weeks or months. These clauses assume that an insurer intends to indemnify and to pay neither more nor less than indemnity up to the limit provided. *Indemnity* for loss of time in health and accident insurance is no different from *indemnity* in fire insurance. Either the intention is to provide indemnity for loss of time or earnings from accident or disease, or to pay more or less than indemnity under certain stated conditions which conditions do not measure the actual loss suffered. The policy submitted proposes to provide indemnity for loss of earnings as limited by the policy, whether such loss be total or partial, continuous, or intermittent; whether or not medical or surgical attendance is necessary, and whether or not there be confinement to the house. The policy, furthermore, provides for the periodic ascertainment and payment of indemnity as so limited.

The character of the disability, whether total or partial, continuous or intermittent, etc., is evidence only of the amount of loss and has no bearing on the question of whether or not the loss was due to accident or disease, which fixes liability. There is, therefore, no necessity for provisions for the payment of benefits for partial disability, and there is no necessity for stating that the loss of time shall be from the business or occupation of the insured. That form of Standard Provision No. 1 which

provides for a reduction of indemnity in the event of a change of occupation to one more hazardous clearly indicates that the indemnity provided by policies formulated under the law must be limited to the payment of indemnity for loss of time, i. e. loss of earnings in the claimant's occupation.

The amount of the liability of an insurer under a contract depends on whether the contract be construed as a valued policy or as a contract of indemnity. A contract of insurance may in fact be a valued policy because the happening of the contingency causes total loss, and because the insured may be unable to pay the premium for full indemnity (Life Insurance), or it may be construed against the insurer as a valued policy because the insurer has knowingly promised a benefit in excess of indemnity. In a valued policy there is no necessity for proof of the amount of loss. All that is necessary is to show that the circumstances and conditions described in the contract exist. Under a contract of indemnity a measurable loss must be established before there is liability. In contemplation of law every contract of insurance is a contract of indemnity, and when a contract is formulated and contains such restrictions and limitations that it may be construed as a valued policy, the courts in health and accident insurance cases will give a claimant not only the indemnity to which he may be entitled but will also grant a recovery in the nature of damages for the fraud which has been perpetrated upon him by the insurer. The policy submitted is a contract of indemnity. The provision for a definite amount of benefit for loss of life by accident is a valued benefit. The amount of insurance provided for loss of time may be construed as a valued benefit only if the insured suffers total and permanent loss of time. If partial or temporary loss of time be suffered the indemnity feature of the contract is emphasized and a claimant has the right to establish his loss for any month and be-

comes entitled to indemnity up to the amount of insurance provided for loss of time for the month.

It is conceded that if it be the intent of a contract to provide a valued benefit for temporary partial loss of time the policy form submitted does not express such intent. It is insisted, however, that such a refinement of the classification of indemnity is not an element of the insurance business under the law, and the consideration of this question, is, therefore, only speculative.

If it be desired to formulate a policy under which the insured shall bear the first part of the loss it will be easy to make such a provision by a rider providing that in consideration of the reduction of the premium by a certain amount the insured agrees to carry any loss up to a certain amount or for a definite period of time; however, such a provision is not authorized by the law. Perhaps the law should be amended.

Paraphrasing the statement of Mr. Page for the instant purpose it would read:

> "Accident and health insurance was primarily designed to indemnify the insured for loss of earnings because of loss of business time caused by accidental bodily injury or disease. It was never intended as a bonus or to put a premium on a specific injury or disability. The benefits provided for specific bodily losses or physical disabilities are in lieu of indemnity for partial loss of earnings and are a commutation of the amount which would otherwise be paid under the indemnity feature providing for the periodic ascertainment and payment of indemnity."

As the provision in the policy submitted for insurance against loss other than that of time was considered, there was a disposition to eliminate the portion of the paragraph providing for the division of the amount of indemnity into periods for the ascertainment of indemnity for such period. The amount of expenses incurred for care and treatment is directly related to the lapse of time only in chronic cases of disease, and, in view of the

conditions in the ordinary case of disability, this portion of this paragraph might be construed as a violation of subdivision (2) of subsection (4) of the Standard Provisions Law, prohibiting any provision in a policy "limiting the amount of indemnity to a sum less than the amount stated in the policy and for which the premium has been paid," unless it be in the form of one of the Optional Standard Provisions. In the ordinary case of disability from accident or disease expenses for operation, medical attendance, hospital and nurses, pile up in a short time, and where disability is short and expenses high there would be a reduction of the indemnity by this provision. The provision for the limitation of the indemnity for loss other than that of time to a definite amount per month has therefore been eliminated in the revised form.

*Cost of Settlements Excessive.* It was anticipated that there would be very strenuous objection to the policy form submitted on the ground that the liability of the insurers would be increased and, therefore, it would be necessary to make a material raise in rates.

It is said that it would be impossible to fix the cost of claims under the policy submitted; that the accumulated statistics on cost would be valueless; that the insurers would be at sea for years as to the premium to be charged; that during the period of readjustment the insurers would be compelled to bear enormous losses to the repairment of the surplus; that the premiums to be charged would be almost prohibitive; that the premiums now charged are fixed by custom and any increase would result in a great decrease in the volume of business, and that the ratios for the different classes of risks would require readjustment. These contentions are obviously inconsistent with each other and are in fact urged in defence of present practices in the business. They disregard the fact that under subsection (9) of the Standard Provisions Law, every policy must be construed under the law. They dis-

regard the fact that the policy form submitted is formulated under the law and that every policy construed under the law must provide the indemnities provided in the policy submitted. So construing present policy forms, the contentions made are an admission that claimants under present settlements are not paid what they are entitled to under the law, and that advantage is being taken of claimants in adjustments.

These contentions in all cases are based on the assumption that there would be a great increase in disbursements for claims under the form submitted. For the insurer who is paying claimants indemnity or what they are entitled to, no increase of premiums would be necessary. The insurer who construes the policy literally and takes advantage of all technical limitations and is not paying what claimants are entitled to should be compelled to do so. Under the policy submitted he would not have even the shadow of a right to reject or reduce claims because of conditions in the policy in no way related to the liability or the amount of the liability or the amount of the loss on which a claim is based. If it is a general practice to cut down claims unfairly because the rates charged are inadequate, an increase of rates must follow the use of an honest policy form. If it is the practice of only part of the insurers to shave claims unjustly, under the form submitted they would be obliged to reduce their pilferings. The contention that disbursement would be greatly increased under the policy submitted, however, is not warranted. In the first place there would be a decided saving on many claims where payments are now made in excess of indemnity. Many claims are now paid where there has been no actual loss with the result that it has been to the advantage of a policyholder to be laid up. There would, therefore, be a large saving on claims which from an insurance standpoint are fraudulent. Moreover, an investigation by the largest health and accident company in this state a year ago showed con-

clusively that if all the sickness claims of the company were paid in full in cases of total disability without confinement to the house, the cost would have been less than five cents per month per policyholder. This amount would be saved by a reduction in the cost of acquisition because of satisfied policyholders. The assumption of an increase of disbursements for claims not only does not take into consideration the savings there would be on claims where payment is made in excess of indemnity, but does not consider the cases where payments are now made for losses not included in the contract, such as medical bills where there has been no loss of time and the contracts did not include medical expenses. The policy form submitted clearly distinguishes indemnity for loss other than that of time from indemnity for loss of time, and no claim could arise under a policy providing indemnity only for loss of time. The effect of the policy on the amount of disbursement would be a readjustment of disbursements on an equitable basis. Probably, honest claimants would get more than they receive under present policy forms. There would, however, be a very large saving on claims which are excessive, either because fraudulent in whole or in part, or because the insurer desires to curry favor by making payments in excess of indemnity as limited by the contract. The objection along this line is mere speculation not based on a study of the question.

The answer to the claim that the accumulated statistics would be rendered valueless is that, by the adoption of the form submitted, the fact would be recognized that from an insurance standpoint the present statistics are practically valueless, and are a hindrance to the accumulation and collation of really scientific statistics which will show the loss incurred because of sickness and the death and bodily injury of the insured by accident, and will furnish the data for making an honest and scientific classification of risks by occupation. The insurer is at sea at present as to what are reasonable and adequate

rates. Present rates are largely guesses based in a large degree on cost of claims to the insurer.

The problem of rates is not to obtain greater premiums but to make a more equitable distribution of premiums now collected, particularly as between the policyholders, and to make savings so there would be a reduction of the expense of acquisition and continuance.

A business which consumes at least fifty per cent of the income of most of its operators and in some cases eighty per cent or eighty-five per cent of the income in expense of operation is very near the extreme of inefficiency, and, obviously, in common sense has as its prime necessity a reorganization of itself for practical efficiency.

The ease with which health rates have been raised in the past on the plea of necessity because of the influenza with an accompanying increase in the number of policyholders is a demonstration that any readjustment of rates necessitated by increased disbursements can be made easily and quickly and does not involve enormous losses and years of time.

It is also a refutation of the claim that the premiums in this business are fixed and unchangeable and an increase of rates would mean a decrease in the volume of business.

*Optional Indemnities.* The provisions for the payment of optional indemnities submitted with the letter of May 21, are criticised as not formulated under the law. and as not providing the insurance authorized by the law.

In the letter accompanying the policy form submitted, the attempt was made to convey the idea that the provisions for optional indemnities were not a part of a contract formulated under the law. It was stated they should not be incorporated into the policy proper and that the insurer could modify, limit, restrict, or enlarge them in any way desired. The only restriction upon them would be that they must be bona fide commutations of the

amounts to which the insured would be entitled for loss of time under the policy. The provisions suggested were taken almost literally from present policy forms.

The criticisms of the optional indemnities submitted are, therefore, criticisms of present policy provisions. As now used they are not logical or formulated in reason or under the law. The law does not authorize such provisions. Considered as provisions of insurance contracts they provide specific amounts of benefits and not the indemnities authorized by the law. They have no place in a policy formulated under the law. In the present policies these provisions are not formulated as offers to pay certain sums of money in case specific disabilities or bodily losses are suffered, in lieu of the indemnity to which a claimant would be entitled under a policy formulated under the law, which sums should be a commutation of the amount which would otherwise be paid under the monthly indemnity features for the periodic ascertainment of the indemnity for loss of time, but they are phrased so that literally construed they are on a par with or even of greater force than the provisions for the payment of indemnity periodically, which is the only unqualified limitation on the payment of indemnity and for a reduction of indemnity recognized in the law. It was assumed that they were honest attempts on the part of the insurers to commute the amounts to which the insured would be entitled for loss of time under the contracts. Authorship is disclaimed and the writer is not called upon to defend them. The sole purpose in suggesting them was to meet the anticipated objection to the policy form submitted that the adjustment of claims would be made more difficult under the form submitted than under the forms now used. There was considerable hesitation in submitting them, originating in the thought that their real relation to the policy might be misunderstood, but it was thought that there was provision against such a misunderstanding by the accompanying letter.

Any provisions in a policy for indemnities not authorized by the law are, when construed most favorably to the insurer, in the nature of offers to settle immediately claims on which the liability can only be determined and established with the lapse of time. The purpose of an offer of settlement is to relieve the insurer of the work of collecting periodically proof of loss and of making adjustments and partial payments. The claimant is relieved of the work of making periodical proof of loss. Clearly an offer of settlement cannot be made until liability has attached.

*Periodic Ascertainment and Payment of Indemnity for Loss of Time.* It is claimed that the provisions of the policy submitted for the periodic ascertainment and payment of indemnity for loss of time are practically impossible of execution in cases where a claimant is not receiving a definite salary, or wages. For instance where compensation is by commissions or for piece work and where a claimant is managing his own business; in cases where employment is not continuous (teachers); where the value of services fluctuates with the seasons (farmers, craftsmen in the building trades); and where disability and loss of time entail no diminusion of income (persons receiving incomes from investments, cases where the employer continues to pay the salary in cases of disability). Curiously enough, this criticism is urged most strenuously by an insurance company official who states "accident insurance was designed primarily to compensate the insured for loss of business time. It was never intended as a bonus or to put a premium on injury." The conclusive answer to this criticism is that indemnity for loss suffered is basic to insurance and where the amount of loss sustained cannot be measured or established, no indemnity can be paid. The answer is conclusive, however, only when a policy providing indemnity is distinguished and differentiated from a policy providing valued benefits.

It is possible to construe a policy providing indemnity for loss of time as a valued policy in case of death or permanent total disability, although the law does not warrant such a construction. In case a policy provides a specific or valued benefit for loss of time from accident or disease, it may be held that death causes a total loss and the beneficiary, therefore, is entitled to the full amount of insurance provided. Furthermore, if there be no definite amount of insurance and a limit to the time for the periodic ascertainment of indemnity for loss of time, the expectancy of life of the deceased must be calculated. Such a construction is a possibility common to the policy form submitted and to the policy forms now being used, and depends on the construction put on a policy form by the insurer. Such a construction may be avoided by differentiating indemnity for loss of life from indemnity for loss of time.

The insuring company may construe an accident or health policy to be a valued policy, and, if so construed by the insurer by placing a provision therein providing for payment to the beneficiary of unaccrued indemnity for loss of time, the courts would necessarily put the same construction upon it. If indemnity for loss of life by accident be distinguished from indemnity for loss of time by accident, and a policy provides both, the insurer would, of course, be liable for both. In the policy form submitted these indemnities are differentiated more clearly than in the law. If the insurer persists in disregarding the distinction, he should suffer for his wilful violation of the law. Indemnity for loss of life is not differentiated in the policies now in use from indemnity for loss of time, and any excessive judgment against the insurer is due solely to their refusals to provide the indemnities authorized by the law.

The complete answer to this objection is that the proof required from a claimant would be entirely in the control

of the insurer. If the insurer wishes to pay a claim without requiring proof of the loss there would be nothing to stop such payment, but, on the other hand, the insurer would have absolute protection against fraudulent claims because the same proof as would be required to sustain the claim in court could be demanded of a claimant.

The practical answer to this objection is for the insurers to lay stress in the conduct of their business on the fact that indemnity is basic to insurance; to issue policies which provide only the indemnities contemplated by the law, and to issue policies which will provide the indemnities needed by the policyholder. For instance, a person who can suffer no loss of time of insurable value should have a policy insuring him against loss from expenses only, i. e. loss other than that of time. Where the value of time varies with the seasons, the policy might provide different amounts of insurance for loss of time according to the season; and where the compensation is by commissions or earnings from a business, a claimant should be required to prove the value of the time lost, and the policy should not provide a valued benefit for loss of time. Of course the insurer is not entitled to a reduction of the indemnity in cases where the person disabled receives gifts; for instance, where an employer continues to pay a salary.

*Partial Loss of Time or Partial Disability.* It is said that no specific provisions for partial disability from the insured's occupation is made in the form submitted, and that such loss is just as insurable a proposition as total loss of time or total disability. The policy is designed to provide indemnity for five kinds of losses; loss of life by accident; loss of time by accident; loss other than that of time by accident; loss of time by disease, and loss other than that of time by disease. There is no attempt to provide a specific benefit for total loss of time, for the law does not authorize such a contract. The law does not authorize a valued benefit for loss of time any-

more than it authorizes a valued benefit for any specific disability.

The limitation upon the amount payable monthly fixes the limit beyond which indemnity will not be made. The limitation of time during which the monthly indemnity will be paid is a further limitation on the amount payable. Both of these limitations are contemplated and authorized by the law. If a policy be construed to be a valued policy, there would be no meaning to these limitations and, moreover, the limitation that the loss must be established by the insured would have no meaning. Insurance up to a fixed amount means that full indemnity will be paid for a smaller loss and that full indemnity will not be paid for a greater loss. There is, therefore, no need for a provision for specific benefits for partial loss of time or partial disability. In the letter accompanying the form it was suggested that an optional indemnity provision for partial loss of time be formulated. This might be practically the same as the provision common to present policy forms with a clause showing it to be a offer to settle a claim under the conditions provided.

*No Provision for Double Indemnities.* No double indemnity provision is placed in the policy for the reason that the law does not authorize this kind of insurance. If the double indemnity provision in the present policy forms be analyzed it is obvious that such a provision provides insurance against loss from certain accidents. The law does not authorize such a contract.

Railway ticket policies, with the limitation that they shall be sold only at railway stations or at railway ticket offices, are excepted from certain portions of the Standard Provisions Law. There is no warrant in the law for combining such policies with other forms. Moreover, the issue of such policies to the general public which is not exposed to the hazard is unjust, even assuming that this insurance is valuable and is provided for a nominal pre-

mium. Some one must pay the premium to meet losses and assuming that the premiums collected are figured to meet losses, under present conditions the class not exposed to the hazard pays the larger portion of the premiums. The fact is that this kind of insurance is of practically no value. One company which has collected more than $300,000 on this kind of policy has paid benefits of only $7,500. A business transaction which gives two and one-half cents of value for an expenditure of one dollar is not a profitable one to the purchaser.

While it is true that the Standard Provisions Law does not undertake to fix the amount of benefits payable, the fundamental purpose in the enactment of the law was to fix and make definite and certain the conditions determining liability. The manifest secondary purpose in the enactment of the law was to assure the payment of benefits to claimants based on the loss actually suffered. Under the law, the occurrence of loss (loss of life, time or other than that of time; from accident, or loss of time, or loss other than that of time from sickness) from the contingencies of accident or disease determines liability, and the right to full indemnity is absolute except in cases where the loss exceeds the amount of insurance.

The common double indemnity provision has been omitted from the policy form submitted for the additional reason that this provision in the policies is exceedingly dangerous for the insurer. The only element in this provision recognized by the law is the amount of insurance provided. In an action for the amount of the double indemnity for loss from an ordinary accident, the plaintiff should logically and probably would recover if this matter were brought to the attention of the court. The double indemnity provisions have not been demanded by the public but are an effect of unfair competition. The public demands them from one insurer because competitors give them. The public would be foolish if it did not take them under existing conditions.

*Increase of Benefits.* Although not mentioned in any of the answers of the insurers, it may be well to discuss briefly the ordinary provisions of present policies providing for an increase of benefits by reason of payment of the premium for a definite time, usually a year, or by reason of renewal of a policy. The primary reason for omitting such provisions from the form submitted for criticism is that such provision disregards the fundamental principle of insurance contracts; namely, indemnity. The violation of this principle results in discrimination between policyholders and in the violation of the antidiscrimination law. Moreover, the provisions mislead the policyholders as to the nature of the contract and very rarely effect an increase of benefits.

*Complaints Inherent in the Business.* It is said that complaints are inherent in the business because human nature is as it is. This objection to the policy form is unwarranted unless the objection distinguishes health and accident insurance from other kinds of insurance. If it be claimed that health and accident insurance is different from other kinds of insurance by reason of the fact that the claimant's own body is affected, then there must be some distinction presented between health and accident insurance and workmen's compensation insurance. The department has at least ten complaints in accident and health insurance cases to one in all other branches of insurance, and it has hundreds of complaints in health and accident cases to one in workmen's compensation. It is obvious that the department receives only a fraction of a percent of the complaints that are made to the insurers and that there are many legitimate complaints which do not reach the department, or even the insurers. The obvious fact is that the numerous complaints are due to the way the business is conducted.

*Moral Hazard.* The objection is made to the policy form submitted that it omits the usual clauses of the policies now being issued designed to protect the insurer

against fraudulent claims. If the scope of the observations be limited to clauses and provisions of policy forms which are held by the insurers to be determinative of liability or the amount of liability and company practices in the settlements of claims be excluded therefrom, the objection is well stated by the Illinois Health Commission as follows:

> "The problems arising from fraudulent claims, malingering and the simulation of injuries and disability are serious problems which will have to be faced under any form of health and accident insurance so long as human nature remains substantially as it is at present constituted. The casualty companies have had valuable experience in dealing with these problems and this experience should be utilized in any attempt that may be made to secure a more general use of health and accident insurance by wage-earners or others."

The law does not authorize contracts under which liability or the amount of liability is determined by the circumstance of immediate, total or partial disability, the attendance of a physician or surgeon, confinement to the house, visible marks on the body, etc. Liability under a policy of health and accident insurance depends on the fact of whether or not the kind of loss embraced in the contract under the law has resulted from the occurrence of an accident or a disease not excepted from the policy. The fact must be established by evidence. The rule of law as to the probative force of such provisions in a contract is stated as follows:

> "The courts are not inclined to pay much respect to provisions of the policy which purport to control or modify the laws of evidence. In case of any disputed material fact the question whether the injury was accidental must go to the jury. The jury, too, is apt to decide the fact upon the testimony before them, without much regard to any rule of evidence that may be specified in the contract." Richards on Insurance Law, section 395.

The rule is more clearly and definitely stated in a case where the policy required a visible mark upon the body as determinative of liability.

> "We are inclined to the opinion that this condition in a policy presents a question of evidence and one of law. At any rate, a provision of this character in an accident policy will not be enforced by the courts, where the tendency would be to stifle the course of justice. While it is true that the relations between the insurer and the insured are contractual, the courts will not permit the accident insurance companies to establish rules of evidence which are wholly at war with fundamental principles of evidence, which govern the courts in the administration of justice." Trone v. Assurance Corporation, XIII, Ohio Dec. 298.

Disability immediately after an accident is evidentiary of the casual relation between the accident and the disability. Postponement of disability raises a presumption of a want of casual relation between an accident and disability. Confinement to the house is evidence of total disability and total loss of time, but is neither conclusive of disability nor of the degree of disability.

Evidence of immediate disability or of postponed disability, the attendance or non-attendance of a physician or surgeon, confinement or non-confinement to the house, etc., *in the proof of loss* are no more conclusive upon the question of liability or the amount of liability under the decisions of the courts, even before the enactment of the Standard Provisions Law, than they are when provisions of the policies. They are not available as defenses in any case.

Under the law the amount of the liability under an accident or health contract is limited to the amount of loss established by the claimant and is also limited to the amount of insurance provided by the policy for that kind of loss. In case a claim be for loss of time there is the further limitation under Standard Provision No. 10 of the indemnity for a definite period of time.

The amount of liability for loss of time, except in cases of loss of life immediately on an accident, can only be determined with the lapse of time. Immediate disability from accident is not an invariable accompaniment of loss of time from accident or disease. The attendance of a physician was impossible in many influenza cases. Confinement to the house is not an invariable accompaniment of total disability from either accident or disease, and if made determinative of liability or the amount of liability tends to malingering and in some cases to an increase of the degree of disability (tuberculosis). I suggest an honest analysis of present conditions as to this disease.

The real or willful failure of the writers of the criticisms to understand the theory of the policy suggested respecting partial losses, which is also the theory of the law, arises out of the failure to differentiate the requisite elements of health and accident insurance contracts from the elements of contracts of wager. These requisites are in no way different from the requisites of any insurance contract. They may be differently regulated and subdivided, but fundamentally they are the same.

As an additional reason for omitting the provisions dealing with the evidence of loss and the amount thereof from the policy form submitted, I desire to suggest that under present conditions the dishonest claimant is the favored claimant. The fraudulent claim is the one that meets all the demands of the present policies and is the one which is paid. Paraphrasing the statement of W. Edward Magruder, M. D., medical examiner and adjuster for accident insurance companies, he says: "Many fraudulent claims are so well prepared to meet the requirements of the policy that many of them are paid by the claim departments without question."

The fraud is told that if he will show certain conditions, "immediate disability from accident," "confinement to the house," "attendance of a legally qualified physician at least once a week," "continuous disability,"

etc., he will be paid certain sums of money regardless of his actual loss, and, naturally, he makes his claim accordingly. The insurers have estopped themselves from rejecting the claim by putting these provisions in their policies and are without defense to fraudulent claims. The honest claimant gives the facts asked for and there is applied to the adjustment of his claim the assumptions made in the policies as to the earmarks of dishonest claims. Under such conditions the honest claimant is manifestly the victim of discrimination.

The purpose of the proof of loss blanks under the form of policy submitted would be to obtain evidence of actual loss and any evidence showing that loss had been sustained and the amount of the loss should be demanded and furnished. The burden of proof would be shifted from the insurer, as is the case at present, to the claimant, as would be just and proper, and the insurer could successfully defend against a dishonest claim on the ground of fraud.

To the honest performance of the insurer's duty, mental integrity is a prerequisite to the preparation of a contract or the adjustment of a claim. The evidence or proof of a claim must be weighed just as it is weighed in every case in the courts. Every claim must be adjusted by someone on the evidence. The honest adjuster has been hampered in his work by limitations and restrictions in the policies which have absolutely nothing to do with determining liability or the amount of liability, and further by the fact that adjusters for competing companies determined liability and the amount of liability according to such irrelevant provisions. The dishonest adjuster, of course, operated most inequitably when he had an interest in rejecting and reducing claims. All controversy would not be removed by the elimination of provisions of this character from policy forms, but the crooked adjuster could not reject or reduce claims for reasons which were not related to the cause of loss and

the loss actually suffered by a claimant and controversies would practically be limited to questions of fact. The policy form submitted would not reform a dishonest adjuster, but it would compel him to make adjustments on the right basis and would give the honest adjuster the advantage his company should have with prospects.

*Defective Pharseology.* The changes in phraseology which have been made in the revision in no way change the insurance provided and would affect in no way the liability of the insurer. In the preparation of the original policy too much force was perhaps given to subsection (9) of the Standard Provisions Law, which provides for the construction of a policy under the law if it be issued in violation of the law. "But why not use the phraseology of the law?" is a pertinent question. This has been done in most of the changes made. Where a change has been made and the phraseology could not be taken from the law the change has been made because possibly the change gives greater clarity.

**Conclusion.** The discussion of the criticisms presented has necessarily been fragmentary, disconnected, and repetitious because the criticisms are manifestly based on no common and comprehensive theory of the business or construction of the law. The criticisms in fact are not real criticisms, but are a defense of present policy forms based on the false assumptions that they are an evolution to meet the demand for this kind of insurance and that the Standard Provisions Law was not designed to regulate the business. The fact that the scope of the field of operation of the insurers in this class of insurance is being constantly restricted by law (workmen's compensation) and the action of the insurers (the manifest tendency to get away from industrial business, where this insurance is most needed, and to do a commercial business exclusively), is conclusive proof that the demand is not being met. The growing demand for social insurance, the shortness of the life of health and accident pol-

icies, the great expense of administrating the business, and the small amount of business as compared with its possibilities, are additional evidence that the business under present conditions is not meeting the demand. Evolution is a process of growth and development and not of elimination and decay. Nothing is being done by present insurers to meet the demand for billions of health and accident insurance. On the contrary, the things which would give the business life and growth are opposed. Under present practices, the cost of insurance is not ascertained, no real rates are calculated and no scientific classifications of risks are made, and yet these are essential if the business is to live and grow.

The conclusions arrived at from a study of the criticisms of the policy form submitted to the insurers differ radically from the general criticism made at the head of one report.

1. The present policy forms are indefinite and ambiguous and literally construed do not provide the insurance authorized by the Standard Provisions Law.

2. The adjustments under present policy forms are inequitable, and if the present forms are continued in use future adjustments must be inequitable.

3. Radical changes in present policy forms must be made if the business is to meet the demands of the future, or even to meet present needs. The immediate change required is health and accident policies formulated to provide the insurance authorized by the Standard Provisions Law.

4. The policy form submitted for criticism and suggestions was designed to provide all the insurance authorized by the Standard Provisions Law and with the slight changes in pharseology in the revised form unquestionably does so.